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REHABILITATION LITERATURE

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REHABILITATION LITERATURE

Article of the Month

Rehabilitation of Patients with Progressive Muscular Dystrophy and Atrophy

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and

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THE PHILOSOPHY and ideal objectives of a rehabilitation program for patients with progressive muscular dystrophy or atrophy are the same as for any other chronic physical disability, namely, to assist the patient in meeting the physical demands of daily living so that he may attend school or be employed in an appropriate capacity. However, complicating factors of variable rates of progression necessitate the goals and objectives of the rehabilitation program being changed as the disease progresses. Also emotional and psychological factors identified with the hereditary aspects of these diseases complicate the psychosocial adjustment of the patients and their families.

The medical profession and the informed public are quite understanding of the nature of poliomyelitis and cerebral palsy, even though the etiology of the latter condition is difficult to detect in many cases. On the other hand, the muscular dystrophies and atrophies include a multiplicity of conditions that are very confused in the medical literature and in the minds of all of us concerned with their etiology, pathogenesis, and natural history. The site of the essential pathology in these diseases is indicated in figure 1, page 272.

Although our primary purpose is to discuss rehabilitation problems of progressive muscular dystrophy, some varieties of progressive muscular atrophy are easily and frequently confused with progressive muscular dystrophy. In a clinic devoted to progressive muscular dystrophy, one may find that as many as 25 percent of the patients do not have the primary disease of muscle (dystrophy) but are patients with one of the neurological syndromes of progressive muscular atrophy. The charitable organizations devoted to helping patients with progressive muscular

dystrophy provide similar services for patients with progressive muscular atrophy. We shall, therefore, discuss briefly the clinical nature and rehabilitation problems of patients with either primary progressive degeneration of muscle (progressive muscular dystrophy) or muscle weakness secondary to progressive denervation of the muscles (progressive muscular atrophy). Restrictions of space will not permit detailed discussion; however, references to more detailed information are provided.

Progressive Muscular Dystrophy

Progressive muscular dystrophy is a primary degeneration of the striated musculature of unknown etiology. There is no present method of preventing, curing, or arresting the inexorable course of the disease.

Clinical Types of Progressive Muscular Dystrophy: The variety of clinical types of progressive muscular dystrophy exhibit different patterns of inheritance and different ages of onset and anatomical sequence of progression. Quite possibly these various clinical types of progressive muscular dystrophy represent different disease entities because of different biochemical etiological factors and, therefore, have a different mechanism of hereditary transmission and natural history.

Onset of this primary degeneration of the striated skeletal musculature ranges from age 2 through at least age 50. This disease has a number of clinical varieties, and many different clinical classifications have been proposed. For our purpose, we have found four clinical designations helpful. Characteristic features of these four clinical types are given below:

1. *Childhood Dystrophy* (Pseudohypertrophic, Duchenne, severe generalized)
 - A. *Mechanism of hereditary transmission:* Sex-linked recessive trait with high mutation rate. Found almost exclusively in the male.
 - B. *Age of onset:* 2-10 years.
 - C. *Sequence of muscle involvement:* Glutei, abdominals, anterior tibial, peroneals, erector spinae. Late and minor face involvement. Muscles of respiration.
 - D. *Prognosis:* Poor. Great majority die before age 20.
2. *Facioscapulohumeral Dystrophy* (Landouzy-Dejerine, mild restrictive)
 - A. *Mechanism of hereditary transmission:* Somatic dominant. No sex predilection.
 - B. *Age of onset:* 10-18 years.
 - C. *Sequence of muscle involvement:* Face, pectoralis major, lower trapezius, deltoid and other scapular muscles, erector spinae, abdominals, glutei, peroneal, and anterior tibial.
 - D. *Prognosis:* Fair—slow but variable. Some patients

with disability live virtually a normal life expectancy.

3. *Myotonic Dystrophy* (Dystrophia myotonica, distal dystrophy)
 - A. *Mechanism of hereditary transmission:* Somatic dominant. Onset earlier in child than parent.
 - B. *Age of onset:* 15-80 years.
 - C. *Sequence of muscle involvement:* Small hand muscles, forearms, anterior tibial. Masseters and sternocleidomastoid nearly always involved. Levator palpebrae superioris (ptosis), facial muscles.
 - D. *Muscle reactivity:* Prolonged contraction of muscles following electrical or mechanical stimulation. Delayed relaxation after strong voluntary contraction.
 - E. *Associated defects:* Gonadal atrophy, reduced libido, cortical cataracts.
 - F. *Prognosis:* Poor. Slowly progressive with involvement of muscles of deglutition and mastication.
4. *Ophthalmoplegic Dystrophy* (Progressive dystrophic ophthalmoplegia)
 - A. *Mechanism of hereditary transmission:* Somatic dominant. Hereditary history in one half the cases.
 - B. *Age of onset:* 1-40 years.
 - C. *Sequence of muscle involvement:* Levator palpebrae superioris (ptosis), extrinsic ocular muscles (ophthalmoplegia), facial muscles, occasionally sternocleidomastoid and other neck muscles.
 - D. *Prognosis:* Good. Disabling but not ordinarily fatal.

It may be observed from the above grouping that all these clinical types are heritable or inherited. Figures 2 and 3 indicate the very significant difference in the hereditary pattern of the childhood type of progressive muscular dystrophy and the facioscapulohumeral type. The childhood type of progressive muscular dystrophy is very rare in females. It is also very rare for the affected males to transmit the disease to their children because, by the time they reach marriageable age, they are so physically handicapped that marriage is not feasible. The disease is maintained in the population by its very high mutation rate.

There is also a great difference in prognosis between the two types of progressive muscular dystrophy whose inheritance is indicated in figures 2 and 3. In the childhood type of dystrophy, the dystrophic process progresses rapidly in the sequence indicated in figure 4, in contrast to the slow progress and different sequence of involvement in facioscapulohumeral dystrophy (figure 5). In the childhood type of dystrophy, the vital capacity becomes progressively reduced and, since the heart muscle is striated musculature, the degeneration frequently involves the heart. Most of these children die before reaching the

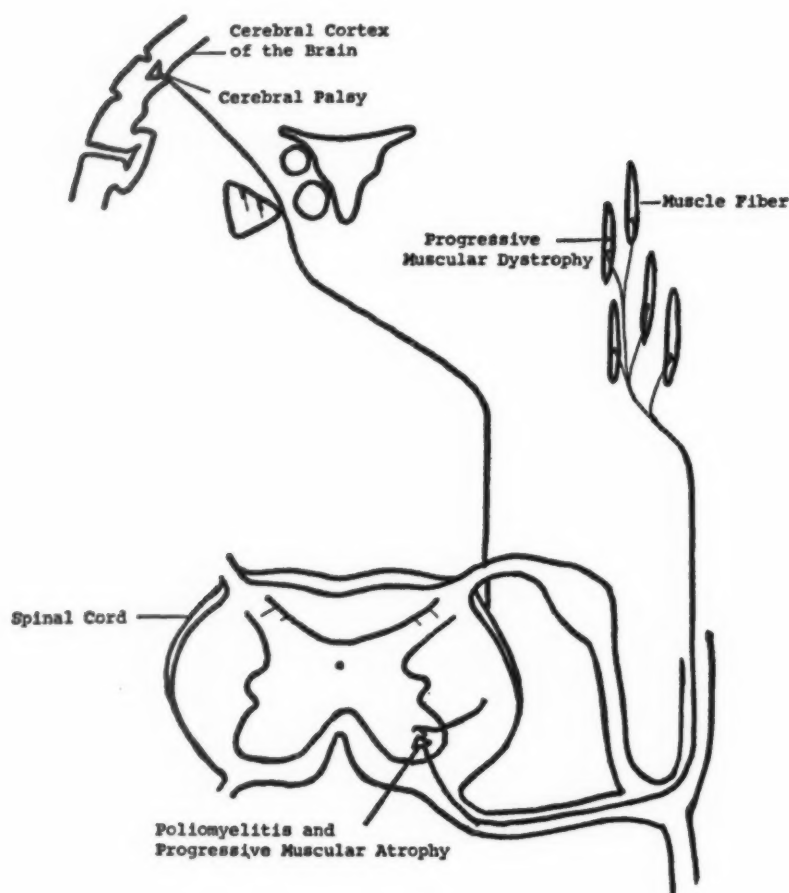


FIGURE 1.—Diagrammatic simplified representation of the site of the pathological lesion in cerebral palsy, poliomyelitis, progressive muscular atrophy, and progressive muscular dystrophy.

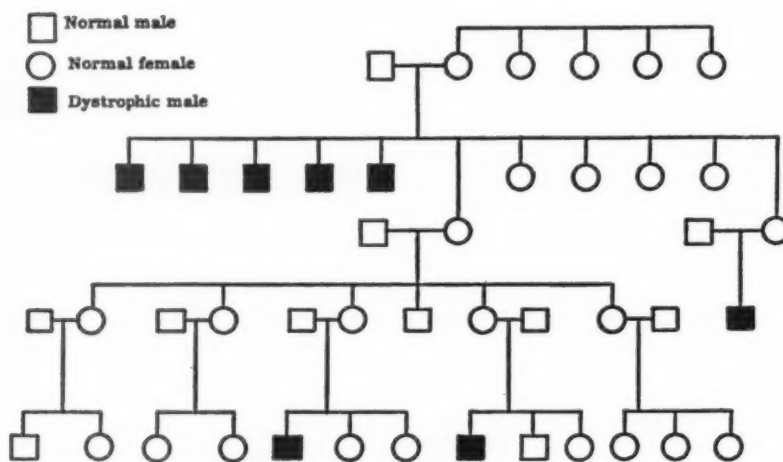


FIGURE 2.—Pedigree of a kindred exhibiting sex-linked recessive inheritance of childhood (pseudohypertrophic) muscular dystrophy. Only males are affected.

age of 20, from either pneumonia, secondary to diminished resistance to infection, or cardiac failure because the heart has become involved in the dystrophic process. Patients with facioscapulohumeral dystrophy have a much better prognosis. The disease involves both sexes equally and they usually have a life span only moderately reduced even though, in later years, they become significantly disabled.

These two types of dystrophy occur the most frequently. We have described the clinical characteristics of other types of progressive muscular dystrophy elsewhere.¹

Nutritional Progressive Muscular Dystrophy: Since 1928 it has been known that deprivation of vitamin E in animals will produce progressive degeneration of striated muscle that can be arrested by administration of vitamin E.² This condition has been experimentally produced in a great many species of animals, but there is no evidence that human progressive muscular dystrophy is in any way related to deficiency of vitamin E or that it can be arrested or cured by the administration of vitamin E.

Progressive Muscular Atrophy

Clinical Types of Progressive Muscular Atrophy: We elect to mention briefly only two clinical syndromes of this group because they are the ones most frequently seen in a clinic devoted to patients with progressive muscular dystrophy.

In 1891 Werdnig³ and in 1893 Hoffmann⁴ described a syndrome of progressive muscular weakness that starts in the latter half of the first year of postnatal life with rapid progression of the paralysis in the trunk muscles, then extends to the muscles of the extremities, with death occurring generally within five years. The laboratory studies clearly indicate this to be a muscle weakness secondary to lower motor neuron involvement.⁵ The disease is inherited either as a recessive or dominant.^{6,7} This condition is commonly known as Werdnig-Hoffmann disease.

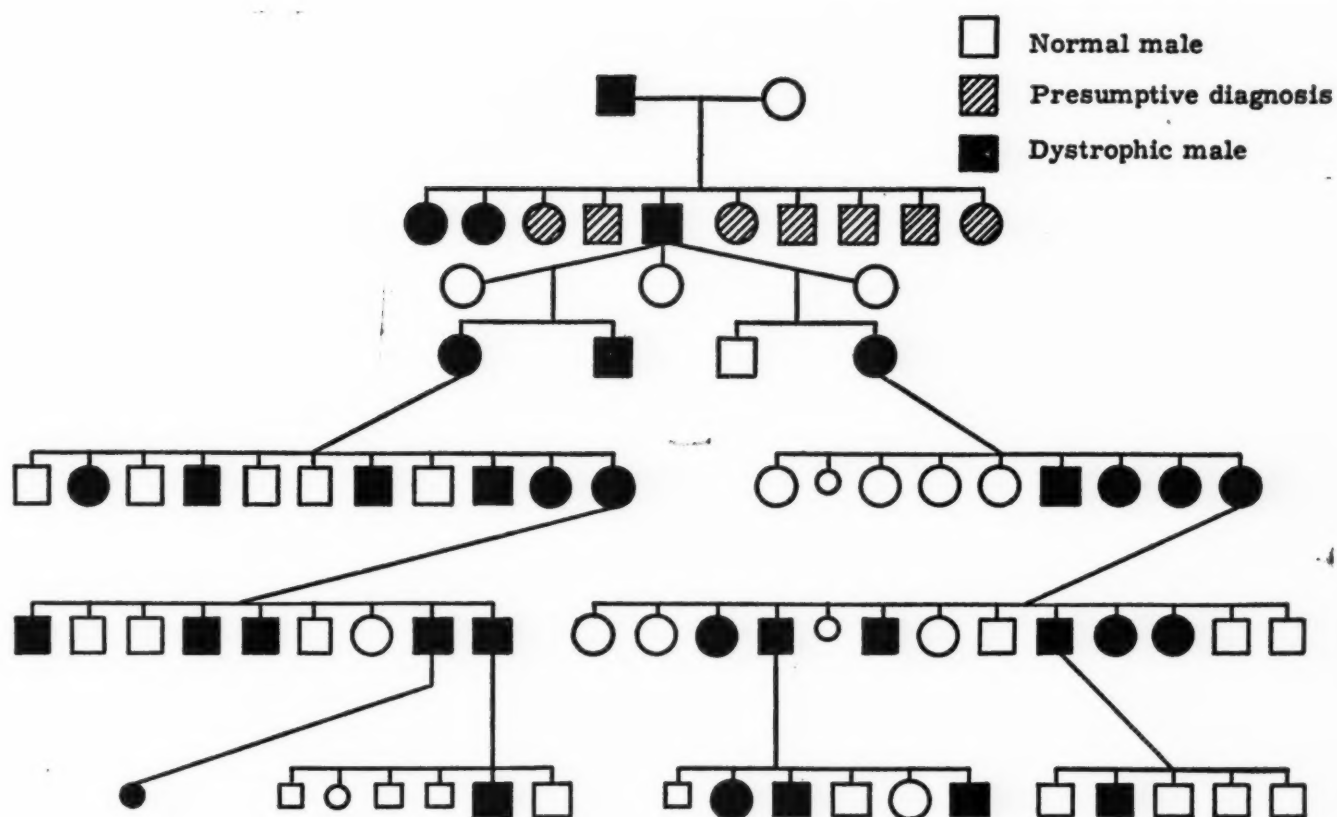


FIGURE 3.—Pedigree of a kindred exhibiting facioscapulohumeral muscular dystrophy. Note the pattern of dominance without sex linkage. Nineteen dystrophic males and 15 dystrophic females in 6 generations of a kindred comprising 79 individuals.

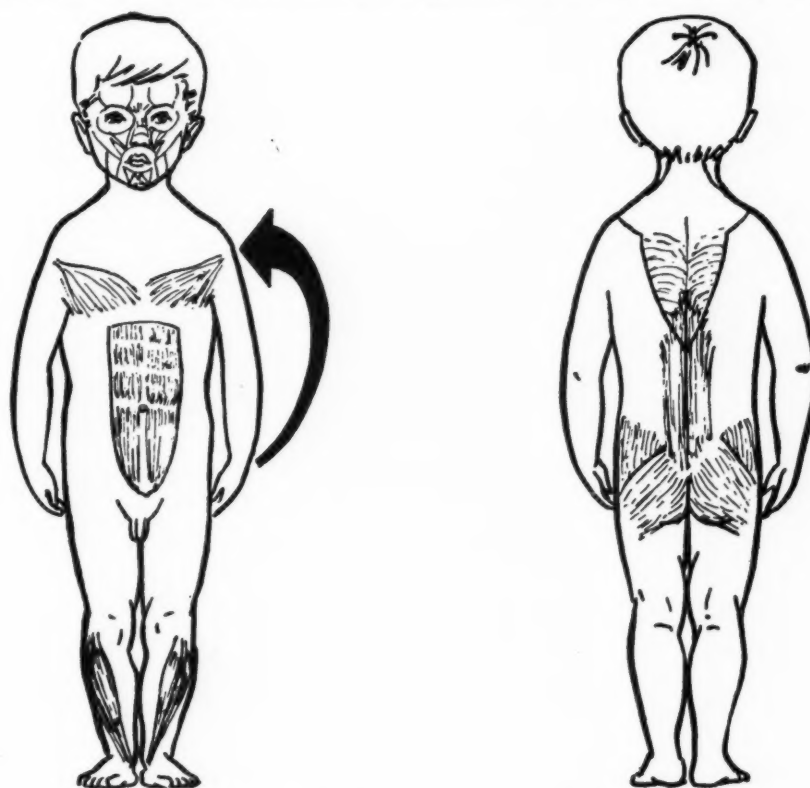


FIGURE 4.—Diagrammatic representation of the initial muscle involvement and the general pattern of subsequent muscle involvement in childhood muscular dystrophy.

ARTICLE OF THE MONTH

In 1900 Oppenheim⁸ described three children born with universal muscle weakness, hypotonia of muscles, and hypermobility of joints (amyotonia congenita). Although Oppenheim emphasized the favorable prognosis and stated that these children improved gradually, the facts are that the three patients described by Oppenheim eventually died and the pathology found was identical with that of the previously described Werdnig-Hoffmann disease. In the United States the concept of a favorable prognosis in amyotonia congenita is frequently expressed; however, most writers^{5,7} believe that these two syndromes are but variants of a single pathological process.

Recently Walton⁹ introduced two new terms into this confused area by describing symptomatic hypotonia, in which the muscle weakness is a reflection of cerebral, nutritional, or metabolic disorders, and benign congenital hypotonia, in which the electrical activity of the muscle is like that of dystrophy but the patients gradually recover. The multiple causes of hypotonia and muscle weakness in infancy and childhood and the great variability of prognosis indicate how important it is for those working with the rehabilitation of these children to have as clear a concept as possible regarding the specific diagnosis and some knowledge of the natural history of the disease. Without this information, it becomes virtually impossible either to plan a rational rehabilitation program or to know whether the rehabilitation procedures applied are per se effective or whether the changes in a patient's functional status are related to a changing pattern of the disease process. Obviously, in such a confused array of neurological and primary diseases of muscles, where we do not possess any accurate etiological data and the distinctive validity of certain of the clinical syndromes is in question, it is difficult and unwise to forecast the eventual rehabilitation goal that might be achieved. Nevertheless, these reflective considerations are essential for planning a rational rehabilitation program and parental counseling.

Physical Evaluation of the Patient

We have attempted to learn more of the natural history of this group of diseases by studying over a period of years the sequence of muscle involvement and relating this to the functional abilities of the patient.^{1,10} We have described the physical status of the patient in terms of eight gradients of functional ability based on the pattern, ability, and method of ambulation and adequacy of activities of daily living. The criteria elected for rating eight stages of functional ability follow:

1. Ambulates with mildly waddling gait and lordosis. Elevation activities adequate (climbs stairs and curbs without assistance).
2. Ambulates with moderately waddling gait and lordosis. Elevation activities deficient (needs support for curbs and stairs).

3. Ambulates with moderately severe waddling gait and lordosis. Cannot negotiate curbs or stairs but can achieve erect posture from standard height chair.
4. Ambulates with severely waddling gait and lordosis. Unable to rise from a standard height chair.
5. Wheel chair independence. Good posture in the chair; can perform all activities of daily living from chair.
6. Wheel chair with dependence. Can roll chair but needs assistance in bed and wheel chair activities.
7. Wheel chair with dependence and back support. Can roll the chair only a short distance; needs back support for good chair position.
8. Bed patient. Can do no activities of daily living without maximum assistance.

Archibald¹¹ used a modification of these criteria, which was found useful for visualizing the natural history of these diseases. When patients with the various types of progressive muscular dystrophy or atrophy are plotted on a grid, using the age at which the patient reaches a given functional state, the striking difference in the prognosis between the various types of muscular dystrophy and atrophy is readily apparent (*figure 6*). In using these gradients, the fourth stage is a critical point at which a patient can no longer obtain an erect posture from the sitting position without being lifted by someone or with a mechanical device. Patients in the fifth stage can be completely independent individuals as long as they have the muscle power to use the wheel chair efficiently. We do not use this grid for purposes of predicting what might happen to a patient at a subsequent age because the natural history of these diseases is so unpredictable that such a procedure might lead one into serious error in rehabilitation counseling.

Physical Therapy in Muscular Dystrophy and Atrophy

Progressive Muscular Dystrophy: Parents of children with dystrophy are frequently convinced that, if only their child could obtain therapeutic exercise on a daily basis, the failing strength that they see could be arrested and the weakness remedied. Abramson¹² found there was some improvement in muscle strength by frequent physical therapy. There was also improved performance of activities of daily living. Hoberman¹³ found in a controlled study that physical therapy did not increase the actual muscle strength. However, there was improved performance of activities of daily living through acquisition of increased skills. It is our opinion that range-of-motion exercises to prevent deformity are useful, that physical exercise is helpful only insofar as it prevents or corrects disuse atrophy and keeps the intact functioning musculature at a maximum level of efficiency. In general the ordinary activities of daily living are sufficient for this

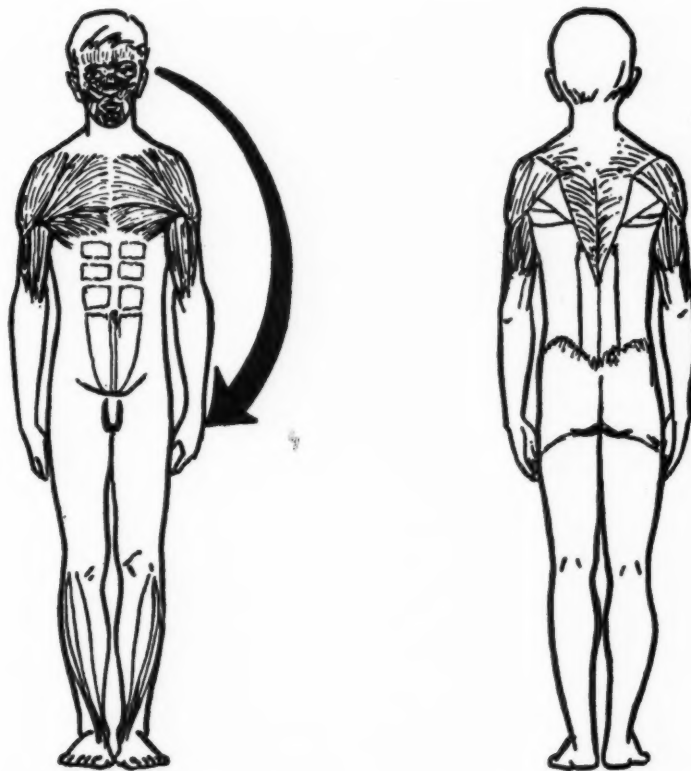


FIGURE 5.—Diagrammatic representation of the initial muscle involvement and the general pattern of subsequent muscle involvement in facioscapulohumeral progressive muscular dystrophy.

purpose in ambulatory patients, and range-of-motion exercises can be done usually on a home basis. There is no need for prolonged routine physical exercise unless, through neglect, contractures have been allowed to develop and reduction of the contracture is a limited objective.

When a child has arrived at the wheel chair stage, special attention must be given to muscle groups essential to maintenance of independence in wheel chair living. Ordinarily, the use of the wheel chair itself comprises the necessary exercise. In our opinion, because of inattention to these details, many children are placed in wheel chairs earlier than is necessary.

Progressive Muscular Atrophy (Amyotonia Congenita): It is apparent from figure 6 that, in some cases of amyotonia congenita, the universal muscle weakness may bring these children to the wheel chair stage about the same time as in the childhood type of progressive muscular dystrophy. In many severe cases, however, these children are never able to ambulate and are destined to a life span of wheel chair use.

In this group of patients also, physical exercise is only of value for the prevention of disuse atrophy and contractures. It is not uncommon to find that certain of these patients are able to perform a variety of functional activities at age two and, as they arrive at age five, they are unable to perform these activities. It has been assumed that

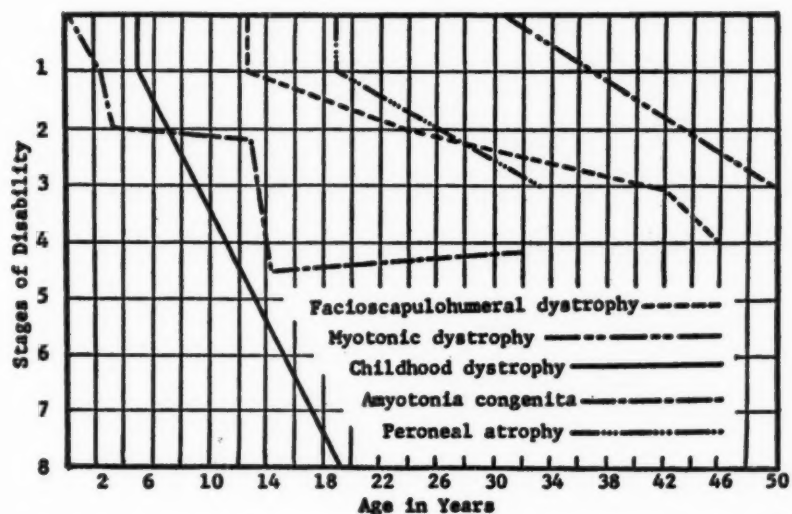


FIGURE 6.—Changes in functional ability as related to age in patients with childhood, facioscapulohumeral, and myotonic progressive muscular dystrophy and infantile (amyotonia congenita: Oppenheim) and adult (peroneal atrophy) progressive muscular atrophy.

this failure in functional ability is a reflection of neurological progression of the disease. We have found, however, in some of these cases, no electromyographic evidence of neurological progression that could account for this decreased functional ability. This possibility is worthy of reflection: Could it be that, at two years of age, these children have a marginal number of functioning motor units that give them barely sufficient power to perform a given activity when the part that must be moved weighs two pounds? At four years of age, the same marginal number of functioning motor units are unable to perform that functional activity when the part concerned weighs four pounds, through the process of growth and development or obesity. Although we have not yet sufficient objective data to substantiate adequately this concept, we have seen a number of cases of progressive muscular atrophy in which there has been a gradual loss of the ability to ambulate through the developmental period. After growth and development were complete, the patient experienced no further loss of functional ability during a 10-year period of wheel chair life.

A number of our patients with amyotonia congenita are in their third decade of life and functioning adequately from wheel chairs. Repeated electromyographic study clearly indicated that these patients have a lower motor neuron disease, but no evidence of progressive denervation could be obtained. The clinical history and findings were in every way compatible with a diagnosis of amyotonia congenita.

Assistive Mechanical Devices Used in Progressive Muscular Dystrophy and Atrophy

Wheel Chairs: The various types of wheel chairs required in the rehabilitative management of these patients are adequately described in many places.^{14, 15}

A child with Duchenne-type (childhood) dystrophy may need a wheel chair at 10 years of age. On the other hand, one of our patients with facioscapulohumeral dystrophy is 65 years of age and a practicing physician in stage four of disability. His severely waddling gait and lordosis give him a grotesque ambulation pattern and, in the event of a fall, he needs assistance to gain the upright position. However, with special attention to and knowledge of his limitations, he practices medicine without too much difficulty.

It should be stressed that the wheel chair should be the right size and have the right accessories to meet the patient's needs. As the weakness progresses, different types of accessories will be needed on the wheel chair.

Braces: No universal rules can be established regarding the use of braces. On occasions, with an early case in which the problem of ambulation is complicated with an unstable foot position, a short-leg brace with a 90°

posterior stop may be all that is required for a number of years but, as the weakness progresses, the bracing must be extended to the point where full control braces are required to support the body in proper alignment. When there is inadequate muscle power for ambulation without braces, the application of braces is of no value for the purpose of ambulation. On the other hand, in such a patient, full control braces are frequently justified to enable him daily to achieve erect standing for physiological and psychological purposes and for the prevention of contractures.

A difficult management problem is the prevention of scoliosis as the weakness progresses in the abdominal and intrinsic back muscles. If structural scoliosis has already occurred, it is virtually impossible to effect much change with the use of back supports. However, early attention to weakness in this area can do much to minimize the development of structural scoliosis. On an individualized basis, we have used a well-fitted canvas corset with semirigid steels or Knight spinal brace in the early stages of back muscle weakness. On occasions, a hinged plastic body jacket lined with moleskin is useful. A significant advantage of back support, not necessarily related to minimizing scoliosis, is that, in wheel chair patients, a back support will frequently improve posture and enable the patient to use his wheel chair much more effectively.

We must emphasize the physiological and psychological value of achieving an erect posture each day. Although this can be achieved by the use of full control braces, in many circumstances, it is easier to effect this erect posture with a tilt table. In a heavy patient, it is frequently easier to roll the patient onto a plywood tilt board placed on the bed than it is to apply braces and try to place him in an erect posture.

Complications of the Rehabilitation Program

1. *Contractures:* An adequate rehabilitation program initiated at the proper time can prevent most contractures. Nevertheless, many clinical patients are first seen after serious contractures have occurred.

Paul¹⁶ and Archibald¹¹ have discussed the medical management of contractures and have pointed out that passive range-of-motion, stretching, and active exercises are effective in treating reducible contractures. Unfortunately, many contractures do not respond to conservative therapy and must be treated with plaster wedge casting or surgical procedures. In this connection, it is essential to elect a procedure that will immobilize the patient for as short a period as possible.

For example, a patient with amyotonia congenita (figure 6) was ambulatory at age 15. When immobilized for one year for multiple surgical procedures to correct her scoliosis, she was subsequently unable to overcome the serious disuse atrophy and has remained a wheel chair patient.

It would appear that, when muscle power is very marginal to functional performance of a task, severe disuse atrophy incident to prolonged immobilization is extremely difficult to overcome and a failure to regain precisely the original marginal power will frequently make the difference between performing or not performing a very vital act of functional importance.

2. *Infections:* In progressive muscular dystrophy, as the dystrophic process involves the primary, secondary, and associated muscles of respiration, there is a progressive decrease in vital capacity. The universal muscle weakness of young children with congenital progressive muscular atrophy results very early in a significantly diminished vital capacity. Many of our patients have vital capacities ranging from 25 to 50 percent of the normal vital capacity for children of their size and age. In these children, an upper respiratory infection that otherwise might easily be managed becomes a serious problem and frequently mechanical respirator equipment must be used. It is unwise to place these patients in tank-type respirators for long periods of time because of the rapid disuse atrophy that occurs. We have found postural drainage and easily applied portable mechanical respiratory aids more effective. The infection should be diagnosed early, the organism identified, and prompt, vigorous antibiotic therapy with a compound of appropriate spectrum initiated as soon as possible. Currently, we are trying to establish the merit of periodic preventive administration of antibiotics.

3. *Cardiac Dystrophy:* In the childhood type of dystrophy, there are frequently characteristic changes in the electrocardiogram.¹⁷ The pathological process in the heart muscle has been studied quite extensively.^{18, 19} Not infrequently, when these patients show signs of cardiac failure, it is difficult to correct the condition with the usual pharmacological agents. It is important to follow closely the changes in the heart in the childhood type of dystrophy because on occasions the heart may fail quite suddenly. Unless the parents are aware of this ongoing process, they may misunderstand the circumstances of death.

Objective data with reference to the cardiac changes in facioscapulohumeral type of dystrophy is inadequate, but it is our impression that this complication is much less common than in the childhood type.

4. *Obesity:* These patients with restricted opportunity for physical activity almost unconsciously have a caloric intake in excess of their needs. Emotional or psychological factors also may contribute to this problem. Often when marginal power is available for the performance of an essential task, a moderate increase in weight will prevent the patient from performing that function. Proper dietary intake and a diversified recreational program will usually prevent obesity and enable the patient to ambulate and be functionally independent for a significantly longer period.

Role of Surgery in the Rehabilitation of Progressive Muscular Dystrophy and Atrophy

Although these patients can and do have the periodic needs for general surgery that one finds in a given population, we are referring to the specific surgical procedures that comprise part of the rehabilitation program. These are performed to correct a malalignment, alter the range of motion at a joint, or correct an instability. Indications for specific procedures will not be discussed.

The decision regarding surgery should be based upon realization that the disease process is progressive. The length of time the patient might benefit must be weighed against the hazards of immobilization. For example, in a case of rapidly progressing childhood dystrophy, a procedure to stabilize a foot would not be warranted if this child were already virtually at the wheel chair stage, because his only erect posture will subsequently be on a tilt table or in full control braces. On the other hand, in facioscapulohumeral dystrophy, a similar procedure might significantly improve functional ability for a long period.

Every procedure must be considered individually in the light of the natural history of the type of progressive muscular dystrophy or atrophy concerned.

Activities of Daily Living

A most challenging aspect of rehabilitation in this group of patients is the ingenuity one can use to find new self-help devices that will afford a patient a greater degree of independence for a longer period and thus contribute to the patient's pleasures of living.

A device adequate at a given time may suffice only for a year or two. As new groups of muscles become involved, different types of self-help devices may be needed. The variety of these items and technics for their use have been described by Buchwald²⁰ and Rusk.¹⁵

Emotional Factors, Hereditary Counseling, and Parental Education

There is very little precise and objective data regarding the emotional problems of patients with progressive muscular dystrophy.²¹ The most comprehensive studies have been those of Morrow²² and Truitt.²³ On occasions, writers have given detailed accounts of theoretically expected reactions of fear, resentment, and hostility based on casual acquaintance with one or two patients said to have progressive muscular dystrophy.²⁴ Too frequently, the essayists have failed to indicate the type of dystrophy with which they were concerned or even whether they were speaking of dystrophy or atrophy.

Certainly, psychological problems engendered in both parents would be related to their understanding of the prognosis of the illness. We have not found the parents of our dystrophic children to be "dead-pan stoics" who "lock away within themselves the strongest and most

devastating emotions of their lives."²⁴ We have found the parents seeking information. If time is taken repeatedly to sit down with them to explain the nature of human inheritance and to point out the hereditary factors in many different diseases with which they may be familiar, they may gain understanding enabling them to cope better with their children's physical and emotional problems.

Although we have not found a childhood case of progressive muscular dystrophy in which the patient at the age of marriage had enough physical ability left to marry and have children, many moderately involved young people with facioscapulohumeral dystrophy have asked about the desirability of marriage and children. We have not found it wise to compute and quote the so-called risk figures but have carefully explained the principles of human heredity. We have suggested that they look at the involvement of their siblings and parents and, on occasions, the involvement they know to be present in their grandparents, to evaluate in their own minds the degree of disability that appears in their family members. They must consider to what degree this familial trait has interfered with the family interpersonal and social life and with their acceptance by friends and community. They are urged to weigh these debits against the assets of a more complete personal life and thus arrive at a conclusion regarding marriage with or without children.

With this group of hereditary diseases, the professional in rehabilitation must not take lightly parental anxieties and questions. Hereditary cases of amyotonia congenita are not nearly as common as those of progressive muscular dystrophy; however, we have always been impressed by the mother who took her first child with amyotonia congenita to the physician and asked: "What are my chances of having another child like this?" The physician jokingly dismissed the thought: "Not a chance in a million. Lightning never strikes twice in the same place."

This mother now has three out of four children wheel chairbound with amyotonia congenita. This example indicates something of the responsibilities the counselor has in providing parents with a basically sound concept of the essential features of heredity and appreciation of some of the vagaries of human inheritance. Provided with this information, they are likely to adopt an appropriate course of action. Whatever course they follow, they will do so with an understanding that will assist them in accepting and providing their children with appropriate care in the event the defective gene is passed.

Summary

To plan a rehabilitation program for patients with progressive muscular dystrophy or atrophy, one should first be certain to which of these categories the patient's illness belongs. The clinical type of dystrophy or atrophy would then be identified with awareness of the difference in prognosis. It is useful to classify the gradient of functional ability in terms of pattern and method of ambulation and efficiency in activities of daily living.

Ambulation without mechanical assistance can be maintained significantly longer if a therapeutic exercise program directed toward prevention of tightness, contracture, and disuse atrophy is maintained. In well-motivated patients, the usual activities of daily living generally provide sufficient exercise. Prolonged routine physical exercise for acquisition of additional strength is not warranted. By proper selection of a wheel chair, braces, and orthotic devices, independence in daily living can be significantly prolonged. As the weakness progresses, one must be alert to altered need for assistive devices. Effective psychosocial service is vital to develop appropriate motivation. Appropriate hereditary counseling for all parents and older children is essential.

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A Collector of Medical History And Anne of Brittany

THE DISTINGUISHED surgeon, Dr. H. Winnett Orr, who died in 1956, was well known for his contributions to surgery. The "Orr treatment" for drainage and rest in wound healing received wide medical attention. This catalog of his collection on medical history documents his love of rare, old books and his generosity to medical libraries. After graduation from the University of Michigan Medical School in 1899, Dr. Orr entered general practice in Lincoln, Neb. On his return from special study during the summer of 1904 with Dr. John Ridlon, professor of orthopedic surgery at Northwestern University Medical School, he with several other Nebraskans proposed building a special hospital for crippled children. In 1905 the state legislature established the State Hospital for the Crippled and Deformed (now the Nebraska Orthopedic Hospital). For 50 years Dr. Orr served the hospital as staff member and consultant.

A Catalogue of the H. Winnett Orr Historical Collection and Other Rare Books in the Library of the American College of Surgeons

Edited by: L. Marguerite Prime

1960. 198 p. plates. American College of Surgeons, 40 E. Erie St., Chicago 11, Ill.

Dr. Orr's active interest in the history of surgery made him an ardent book collector for 35 years. The H. Winnett Orr collection, which he gave the library

of the American College of Surgeons, consists of some 2,600 volumes, many rare and classic items. In the sections on general and orthopedic surgery and physical medicine, one notes many titles particularly pertinent to the care of crippled children and the treatment of wounded soldiers. His books *Osteomyelitis and Compound Fractures and Other Infected Wounds* (C. V. Mosby, 1929) and *Wounds and Fractures; a Clinical Guide to Civil and Military Practice* (Charles C Thomas, 1941) have a rightful place in this historical collection. A third book, *Anne of Brittany*, published privately by the author in 1944, deserves special mention.

While a member of the American Expeditionary Force in World War I, Dr. Orr visited the famous cathedral at Nantes. There he saw that one of the angels of the monument erected by Anne of Brittany as a memorial to her parents had a deformed hip. This was a figure of Anne herself, born with a congenital dislocation of the hip. Dr. Orr's interest in her orthopedic problem quickly expanded into an admiration of Anne's accomplishments as duchess of Brittany and queen of France. Until his death, one of Dr. Orr's major hobbies was collecting books and mementos about Anne. This collection of over 1,000 books, maps, pictures, stamps, and coins is now on display at the Love Memorial Library, University of Nebraska. *Anne of Brittany* is Dr. Orr's tribute to a woman with exceptional character who lived with a physical handicap.—*The Editor*.

Review of the Month

Two Guides for Management and Staff Basic Accounting Procedures Cost Accounting, Budgeting, and Statistical Procedures For Rehabilitation Centers and Facilities

by
Basil J. F. Mott
Ronald F. Kovener
and
Max A. Mergle

*Published by the National Society for Crippled Children and Adults, Inc., 2023 W. Ogden Ave., Chicago 12, Ill.
1960. 54 p.; 79 p. tabs., forms.*

About the Authors . . .

Mr. Mott, principal investigator of the study, in June became associate director for the Center for Rehabilitation Services, New York University. Following service as a naval aviator (1943-1946), he was graduated cum laude from Amhurst College (1949) and received an M.P.A. degree from Harvard University (1953). He held the positions of management and program analyst for the U.S. National Institutes of Health, Bethesda, Md. (1955-1957). Mr. Kovener and Mr. Mergle are on the staff of the public accountant firm Arthur Andersen and Company, Chicago. The guides are a result of a three-year research project, supported by a grant from the U.S. Office of Vocational Rehabilitation.

About the Reviewer . . .

Mr. Caniff, executive director of the Conference of Rehabilitation Centers and Facilities, Evanston, Ill., received his B.A. degree from Evansville College in 1948. During World War II, he was a Marine Corps squadron commander. Mr. Caniff was operations supervisor, Sky Service Corporation (1948-1949), executive director, Vanderburgh County (Ind.) Society for Crippled Children and Adults (1949-1959), and executive director, The Rehabilitation Center, Evansville, Ind. (1950-1959).

Reviewed by Charles E. Caniff

THE REHABILITATION CENTER has been one of the fastest growing and more popularly supported social institutions in the field of health and welfare during the period since World War II. The "rehabilitation concept" is rapidly being adopted as a philosophy of program conduct by a large variety of public and private agencies as well as institutions providing all types of services to people with problems. While few people would argue that the concept is really new, its growing acceptance as a basis for health and welfare service programs is a major social phenomenon of the past 15 years.

I believe there are three fundamental reasons for the new approach to the provision of human welfare services: Through advances in medicine and related sciences, we are actually creating a larger body of handicapped people—children with congenital anomalies who formerly would not have survived long after childbirth now are saved; more persons injured in serious accidents or disabled by illness also survive; and as we live longer we become victims of the degenerative but not killing diseases. With the tremendous growth of our economy, money is available and people are willing to use it for welfare services that go beyond maintenance at the bare subsistence level. They are also finding that the ultimate cost is less. The catalyst of these developments was the emotional stimulation and the intellectual awareness created by the impact on the public and the professions of returning disabled servicemen and the demonstrated value of organized programs for their rehabilitation.

The rehabilitation center and the less comprehensively programed rehabilitation facility have become the major proving ground for developing and refining service programs that apply this "rehabilitation concept." From less than a half dozen centers prior to World War II, we now have over 200, with more being planned or under construction. There are probably 2,000 more rehabilitation facilities providing specific phases of a total rehabilitation program.

During this 15-year period, the problems and technics of providing rehabilitation services in an institutional setting have been the topics of hundreds of meetings, workshops, books, articles, and studies. While all the problems of service programing and interprofessional relationships are far from resolved, a very impressive body of knowledge has been developed, and at least pragmatic solutions on an individual situation basis have been applied to the interprofessional problems.

Unfortunately for the long-range welfare of the rehabilitation center movement, the administrative problems inherent in the operation of a highly complex service program in an institutional setting have not received their proportional share of attention. I think this is only natural in such a young and intellectually stimulating movement, particularly when we note that a very large number of center administrators have come to their positions from a professional background, with little preparation for their management responsibilities other than a high level of intelligence and perhaps a "natural bent" for administration. The very momentum of the movement and the ability to resolve financial problems through intensified fund-raising efforts have permitted centers to overlook or postpone resolution of some very fundamental weaknesses in their administrative structure. (I should like to emphasize here that I am discussing rehabilitation centers generically and not as individual entities.)

But as a movement matures in its program skills, it must also develop the ability to define its scope and dimensions and have available the tools necessary to guide its future direction as well as meet a growing number of daily problems. Rehabilitation centers are no exception, and today they are encountering some very real problems that can be resolved only by careful analysis and intelligent action based on sound, well-developed information. Some centers are finding that their caseload for physical restoration is falling off, or at least not increasing at the pace that was anticipated. Other centers are finding that program costs are increasing much faster than income and increased fund-raising activity is not adequate to fill the financial gap. There has been a very general disappointment at the slow rate of development of "third-party purchasers" of center services by public, private, and proprietary groups. The day-to-day internal

operating problems also increase as center programs grow in size and complexity.

Whether we are discussing an individual center or the movement as a whole, problems of these types must be resolved at the policy-making and management level. To make wise decisions boards and administrators must have factual information that is systematically developed and that describes the operational activities and trends in the center.

During the past three years, a research team headed by Basil J. F. Mott has been studying the rehabilitation center movement from an administrative point of view, with the purpose of defining the shape and character of the rehabilitation center movement and developing administrative procedures that would provide information essential to effective management. The two guides "for management and staff" are the first published results of this study. They provide an organized system of obtaining the basic fiscal and statistical information that has been much needed by many individual centers as well as the movement generally. In both the books, the authors demonstrate that they have become well grounded in rehabilitation center philosophies and operational problems. They recognize accounting and all forms of record keeping as tools of administration and keep this perspective as they outline the proposed system and procedures.

In *Basic Accounting Procedures for Rehabilitation Centers and Facilities*, the authors discuss the background from which they have approached the problem and present a proposed uniform chart of accounts. This is the kind of very basic information that is all too often overlooked or taken for granted, but which is the foundation for any well-administered program. The accounts provided are sufficiently detailed to meet the needs of most centers, and smaller facilities will undoubtedly want to select only those needed in the specific operation. Explanations of the functions and use of all major accounts are given and examples provided of reports, transactions, and adjustments that might occur.

The guide on *Cost Accounting, Budgeting, and Statistical Procedures for Rehabilitation Centers and Facilities* provides the advanced course in center management. The authors not only outline technics for determining costs and developing statistical reports but carefully define their importance and use in accomplishing in the most effective manner possible the center's basic purpose—rehabilitation of handicapped persons.

I was particularly impressed with the authors' discussions of fees. They have very clearly defined the principles involved in establishing a fee structure and have discussed the different philosophies. While they rightly leave the development of policy to the individual facility, they have provided some clear guidelines that are

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basic for consistent policies. They have just as clearly presented the problems and approaches to budgeting.

In too many instances, statistical procedures and reports gathered and prepared in rehabilitation centers are used almost wholly as historical documents—to tell the staff, the board, and the community where the center has been and what it has done. While this is an important and useful function, there is a much more significant role that they can play if the proper information is gathered on a consistent, accurate, and current basis. Properly used and interpreted, this information is invaluable to management in spotting changes in caseload, breakdowns in productivity, or significant fiscal variations. The information can then be used as a tool in making policy adjust rapidly to changing conditions. A less immediate but just as important implication is the opportunity this system provides for centers to standardize methods of measurement of their activities so that a reporting system can be developed among centers for use in defining the shape and direction of the total movement.

At first glance at the examples of forms and reports, many center directors may be concerned with their number and complexity. They should remember that these materials have been developed to meet the more complex situations and the forms can easily be simplified or adapted to the smaller operation. This was proved to my own satisfaction through the actual experience of establishing the basic system in a relatively small outpatient center. With the help of our auditor and the staff services of a part-time bookkeeper, the basic system of accounting, cost finding, and reporting was installed. Without question we were putting in more work, but the resulting information was more meaningful and useful than that we had been getting. In fact, in some instances, we were able to cut out time-consuming procedures and still obtain more complete data.

There are relatively few people, particularly in the health and nonprofit organizational group, that "get

excited about" accounting, statistics, and reports. But, even if these are not exciting, they constitute the most basic elements in the building blocks of effective administration, including financial stability and sound program planning.

Rehabilitation centers have been developed and have grown to this point largely through the stimulation of sound theoretical concepts of human welfare and the hard work of volunteers and professional workers coupled with enthusiastic public support. As these concepts spread and become adopted by other institutions and agencies, efficient administration and realistic planning become more vital to the growth and stability of centers. These two books provide a consistent, practical system of accounting and record keeping that can be used to improve administrative procedures in many centers. Uniform adoption of the system by all centers will give the movement an opportunity to collect information that will help define its present scope and dimensions and provide guidelines for planning future directions.

The guides were published as part of a research project of the National Society for Crippled Children and Adults, under a grant from the Office of Vocational Rehabilitation, Department of Health, Education, and Welfare. The authors were assisted by an advisory council composed of distinguished leaders from the Conference of Rehabilitation Centers and Facilities and specialists from the fields of finance and accounting. The rehabilitation center movement owes a debt of gratitude to these agencies, individuals, and the authors for this major contribution to more effective management. However, publication of the guides is only the first step. Now we need an effective means of motivating and helping rehabilitation centers and facilities to adopt the system and install the procedures. If the study was worth doing, and if the procedures developed are sound, then a real effort should be made to guarantee their application by our country's rehabilitation centers and facilities.

Other Books Reviewed

623

Blind Children in Family and Community

By: Marietta B. Spencer; photographs by Frank Agar, Jr., and Carol Safer

1960. 142 p. illus. University of Minnesota Press, Minneapolis 14, Minn. \$4.25.

PARENTS AND ALL THOSE who are concerned in the training and welfare of blind children will find this book, consisting mainly of attractive photographs of pre-school blind children engaged in situations and activities common to all children, a most interesting guide. Through

brief explanatory comments accompanying each picture, ways of relating basic principles of child development and guidance to blind children are demonstrated. The principles are applicable also to children with other physical handicaps. Rather than being, in a true sense, a manual for parents of blind children, the book emphasizes the common problems and needs of young children and how parents, family, and community can aid the child's general adjustment to living. The idea for this survey grew from a study of blind children sponsored by the Minnesota Services for the Blind. A grant from the Hamm Foundation of St. Paul and assistance from the American Founda-

tion for the Blind made possible its publication. Mrs. Spencer is a medical social worker, with a graduate degree from the University of Minnesota. Her experience in counseling with parents of blind children has made her particularly aware of what the community can do to help these children attain normal growth and good social adjustment.

624

The Development of the Infant and Young Child, Normal and Abnormal

By: R. S. Illingworth, M.D.

1960. 318 p. illus., figs., tabs. Published by E. & S. Livingstone, Ltd., Edinburgh, and available in the United States from Williams & Wilkins Co., 428 E. Preston St., Baltimore 2, Md. \$6.50.

THIS BOOK, authored by a well-known British pediatrician who is professor of child health at Sheffield University, presents his views on the mental development of children of preschool age. He believes there is real need for just such information, telling in simple language how the work of Gesell and others can be applied in everyday pediatric practice. Prenatal, perinatal, and subsequent environmental factors influencing child development are discussed in some detail. The association of physical defects and of disease with mental development, the diagnosis of mental retardation and of cerebral palsy, and the variations in the general pattern of development are discussed in separate chapters. The normal sequence of development is described in accordance with theories and experience of Dr. Gesell under whose tutelage the author learned the fundamentals of child development. History-recording and examination technics and the difficulties encountered in differential diagnosis are discussed also at some length. Extensive bibliographies following each chapter and numerous illustrations add to the book's interest and usefulness.

625

Education of the Cerebral Palsied in the South; A Report of a Study. . .

By: Southern Regional Education Board (Directed by William C. Geer and William G. Wolfe, with the assistance of Artis Ingram and L. Leon Reid)

1960. 74 p. tabs. Southern Regional Education Board, 130 Sixth St., N.W., Atlanta, Ga.

RESULTS OF A SURVEY made possible by a grant-in-aid from the Easter Seal Research Foundation are presented in this report. Extensive data were secured from teachers of cerebral palsied children in regard to self-evaluations of their competencies in this field. Colleges

and universities offering training courses for teachers planning to work with crippled children reported on curriculum content and their estimates of the effectiveness of the training programs. Problems most often encountered in teaching cerebral palsied children were enumerated by teachers who were also asked to suggest how educational programs could be improved. Training programs for therapists working in educational settings were evaluated by the therapists themselves and the training institutions. Educational programs in 15 states of the Southern region were surveyed; findings indicate that major emphasis needs to be placed on the education of teachers already working with cerebral palsied children. Action should be taken both to upgrade the teachers of these children and to extend and improve programs offered in teacher training institutions. The study should be read by all those responsible for training personnel and for administering educational programs that include the cerebral palsied.

626

Handicapped Youth; A Report on the Employment Problems of Handicapped Young People in Glasgow

By: Thomas Ferguson and Agnes W. Kerr

1960. 141 p. tabs. Published for The Nuffield Foundation by Oxford University Press (London) and available in the United States from Oxford University Press, 417 Fifth Ave., New York 16, N.Y. \$3.50.

RESULTS OF EARLIER studies of the employment problems of disabled young people in Glasgow prompted this further study of nearly 1,000 children with cardiac disability, other physical handicaps, or mental retardation. These earlier studies were purely fact-finding in scope; the current study was in the nature of a follow-up to see what steps could be taken to improve their postschool performance. Detailed data and case histories illustrating the problems many of the handicapped young people face and the factors considered responsible for their success or failure in finding and keeping employment are included. The chapter on mentally retarded young people in their early 20's discusses information obtained during interviews held in their homes; an attempt was made to determine how far their subsequent performance since leaving school had been influenced by social background and limited scholastic ability. All had attended special schools for the mentally handicapped in Glasgow.

The earlier studies were listed and annotated in *Bul. on Current Literature*, Oct., 1952, #826, 827, and Aug., 1955, #835.

627

Readings in Rehabilitation Counseling

Edited by: C. H. Patterson, Ph.D.

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1960. 324 p. figs., tabs. Spiral binding. Paperbound. Stipes Publishing Co., 10-12 Chester St., Champaign, Ill. \$5.25.

DESIGNED AS A supplementary text for graduate courses in rehabilitation counseling, this book should be most useful in orientation institutes and inservice training of counselors and a ready source of reference for the counselor in the field. With the exception of four previously unpublished papers, the readings include only journal articles, all concerned with the theory and practice of rehabilitation counseling. No articles on research or on counseling problems in specific disability areas have been considered. Emphasis is on the general principles and practices applicable to all disabilities. Of the 64 articles, representing 63 authors, from 17 journals, all but 12 have been published in the period between 1954 and 1959. The list of authors includes well-known leaders in the field of rehabilitation. The 10 topical sections of the book, each beginning with an introduction by the editor and containing references to additional literature on the particular topic, cover the basic philosophy of rehabilitation, role and training of counselors, counseling technics, concepts of rehabilitation centers and sheltered workshops, the role of related professions, and integration of services. As a reference tool and survey of the recent authoritative literature, the book should have wide acceptance. The editor is associate professor of education and director of rehabilitation counselor training at the University of Illinois. He is a frequent contributor to professional journals and the author of several books on counseling. (See *Rehab. Lit.*, June, 1958, #717, May, 1959, #452, and Aug., 1959, #607 and 681.)

628

The Rehabilitation of Potentially Employable Homebound Adults

By: Edith L. Kristeller, M.D., Project Director, and Leo L. Stein, Ph.D., Project Co-ordinator (with the cooperation of the Department of Physical Medicine and Rehabilitation of New York University Medical Center)

1960. (129) p. tabs., graphs, forms. Planographed. (U.S. Off. of Vocational Rehabilitation grant no. 44-56) Issued by Dept. of Physical Medicine and Rehabilitation, New York University Medical Center, 400 E. 34th St., New York 16, N.Y.

BECAUSE OF ENCOURAGING results of a pilot study conducted by the Department of Physical Medicine and Rehabilitation of New York University-Bellevue Medical Center in 1954, a grant was obtained from the U.S. Office of Vocational Rehabilitation to undertake a three-year study to determine the value of providing comprehensive evaluation-rehabilitation services to accept-

ed applicants for homebound employment. This report of the completed study of 48 homebound clients presents a mass of data on general characteristics of the patient population, vocational status at initial evaluation, medical findings, and psychological and social evaluations. Forms used in recording data during the study are included in the report. Findings of the study should encourage further research in this area of rehabilitation since so few studies are presently available bearing on vocational potential of the homebound.

629

Selected Articles on Nursing Homes

Compiled by: U.S. Public Health Service

1960. 287 p. illus., tabs. (*Public Health Serv. publ. no. 732*) Paperbound. U.S. Superintendent of Documents, Government Printing Office, Washington 25, D.C. \$1.50.

THIS IS a compilation of 47 reprints of significant articles and speeches dealing with current problems of interest to nursing home administrators and personnel. Discussed are nursing and medical services, dietary services, administration, standards for improvement of patient care, and financial aspects of care. A directory of state agency and program directors responsible for the licensure of hospitals, nursing homes, and homes for the aged is included in the appendix; it should prove a useful reference source. A brief list of selected references provides additional sources for information in this field. The book was prepared by the Chronic Disease Program, Bureau of State Services, USPHS, primarily as an aid to state and local agency personnel.

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Understanding and Teaching the Dependent Retarded Child

By: Louis E. Rosenzweig and Julia Long

1960. 185 p. The Educational Publishing Corporation, Darien, Conn. \$4.25.

WITH THE RAPID expansion of educational opportunities for mentally retarded children considered unable to profit from inclusion in the normal classroom, a shortage of trained personnel has developed. For the teacher comparatively untrained or lacking experience in the technics of special education, this book should prove useful, with its detailed description of the four major levels of mental retardation, the criteria to aid in selection of pupils for admission to "trainable" classes, and maximum and minimum goals that the retarded can be expected to achieve. While the first two chapters are theoretical, the remainder of the book has practical application to

(Continued on page 286)

Teachers of Exceptional Children for the West

Findings, Conclusions, and Recommendations

Major Findings

I. While more than half a million children of school age in the Western states are "exceptional" enough to need special education, only about 260,000—less than half—are receiving special education services of any kind.

II. More than 21,000 specially trained teachers are

Teachers of Exceptional Children for the West (1960, 40 p.) reports a regional survey by the Western Interstate Commission for Higher Education, Fleming Law Bldg., Boulder, Colo. This article, an excerpt from the report, quotes from pages 5 to 7 the major findings and recommendations of the Report Review Committee. Dr. Lloyd M. Dunn conducted the study, assisted by Terry F. Lunsford of the Commission staff. Members of the Report Review Committee, listed in the report, include leading educators of the area surveyed. The Commission is an interstate research and planning agency created by the Western Governors' Conference in 1950 under the only compact embracing all 13 Western states. A major responsibility of the Commission is to study the region's needs and resources for graduate and professional education. Harold L. Enarson is director of the Commission. The survey reported in *Teachers of Exceptional Children for the West* was supported in part by grants from the Easter Seal Research Foundation and the United Cerebral Palsy Research and Educational Foundation.

needed to educate these children, but today the West employs less than 8,000 such teachers.

III. Less than half the special educators employed in the Western states today have completed full programs of preparation for teaching in their special education field.

IV. In almost every area of special education, the demand for trained personnel in each of the next five years can be expected to exceed the supply of specialists in these fields being produced by Western college and university training programs, even though this demand will be far below the number of teachers needed to educate our exceptional children.

V. During the past five years, the number of Western colleges and universities with training programs in special

education has more than doubled, increasing from 21 to 45.

Conclusions

I. The Western states and training institutions need to plan together for strong training programs for teachers of handicapped and gifted children, if they are to avoid a haphazard growth of training programs unrelated to the region's personnel needs, the numbers of students available for training, and the financial resources upon which training programs can call.

II. More effective recruitment of students for teaching careers in special education is vitally necessary if Western training programs are to produce the specialists the region needs in this field.

III. The citizens of the Western states generally need to see more clearly

A. that they have a responsibility for the education of those children who are so different from normal children mentally or physically that they require teachers specially trained to meet their needs.

B. that the shaping of education to the special needs of these children is within our national tradition of using education to help each individual realize his abilities to the fullest extent.

C. that an investment in the education of these "exceptional" children can bring a sound return to the states' economies, by allowing them to grow up as productive citizens instead of life-long community burdens.

Recommendations of the Committee

I. We recommend that each Western state:

A. make periodic studies of its own needs for specially trained teachers of each type of exceptional child.

B. consider establishing state scholarships to help its residents undertake training in special education.

C. consider participating in the financial support of interstate training programs in this field.

D. develop high standards for the certification of special educators, consistent with those in other states, so as to raise the quality of teaching and to facilitate interstate co-operation in the training of such teachers.

SPECIAL REPORT

II. We recommend that Western colleges and universities:

A. carefully evaluate their offerings in speech and hearing and in other areas of special education, with emphasis on the quality of offerings and on the personnel needs of their communities, states, and region.

B. develop training programs in these fields to meet interstate needs, and that each of these programs be conducted on a year-round basis with at least one full-time faculty member in each specialty offered, with adequate laboratory facilities, and with the other requisites of a quality program.

C. operate training programs in special education fields wherever necessary to meet clearly identified local needs, in addition to year-round training programs developed for interstate purposes.

III. We recommend that vigorous efforts be made by state agencies, training institutions, and citizens' and professional groups to attract able students to special education fields.

IV. We recommend that two or three strong programs be developed in the West for training leadership personnel to stimulate educational programs for *gifted* children. We further recommend that the states and the training institutions emphasize research into the kinds of education that are of greatest value to these children.

V. We recommend:

A. that Western colleges and universities conduct continuing research into the proper content of training programs for teachers of *severely maladjusted* children.

B. that consideration be given to the establishment of two or three pilot programs in the West for this purpose.

C. that both states and training institutions investigate the need for establishing more training programs in this specialty.

VI. We recommend:

A. that the number of training programs for teachers of *mentally retarded* children in the West be increased to at least 12 programs for the Pacific Coast states and at least 5 or 6 programs for the remainder of the region.

B. that three or four of these programs be enabled to conduct research into the effectiveness and content of training programs for the mentally retarded, and to offer doctoral training in this specialty.

VII. We recommend:

A. that one or two strong programs be developed in the West for interstate purposes to train teachers qualified to work with both *blind and partially seeing* children.

B. that summer programs be developed that would rotate among Western colleges and universities, to meet local needs for inservice training and recruitment in this specialty.

VIII. We recommend that two or three high-quality programs be developed in the West for interstate purposes

to train teachers of children with *cerebral palsy and other neuromotor disorders*.

IX. We recommend that colleges and universities in the West continue to provide training for teachers of *hospitalized and homebound* children through summer sessions and inservice training programs, and through two or three year-round programs for teachers of children with cerebral palsy and other neuromotor disorders.

X. We recommend that four to six strong programs be developed in the West for interstate purposes to train teachers qualified to work with both *deaf and severely hard of hearing* children.

XI. We recommend that no additional training programs for *speech and hearing* specialists be developed in the West unless intensive study indicates a strong need for them.

XII. We recommend:

A. that four strong *doctoral programs*, geographically distributed over the region, be developed in the West to train state and local supervisors and college faculty members in special education, including one or more programs serving the State of California.

B. that doctoral programs be maintained only at institutions having strong bachelor's and master's degree programs in three or more areas of special education.

C. that no additional doctoral programs in speech and hearing be contemplated in the West unless intensive study reveals a need for them.

XIII. We recommend to the Western Interstate Commission for Higher Education:

A. that it help the Western colleges and universities to achieve a balanced growth of high-quality specialized training programs in special education, and to avoid unnecessary and inefficient duplication of offerings in this field.

B. that it assist in the development of regional and subregional training programs in special education that can serve the needs of several states.

C. that it assist these interstate training programs to obtain financial support from private foundations, states, and federal agencies.

(Continued from page 284)

classroom planning and activities to promote skills in self-help, social adjustment, motor ability, and academic and vocational areas. Suggestions for recreational activities are included along with a list of audiovisual aids the teacher should find valuable in the special class. An outline for classroom organization, lesson planning, and equipment for teaching children with chronological ages ranging from 5 to 17 is given. Parents could use the book to advantage in home teaching of the preschool or older child where classes are unavailable.

Journal articles, chapters of books, research reports, and other current publications have been selected for digest in this section because of their significance and possible interest to readers in the various professional disciplines. Authors' and publishers' addresses are given when available for the convenience of the reader should he desire to obtain the complete article or publication. The editor will be most receptive to suggestions as to new publications warranting this special attention in Digests of the Month.

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The Changing Role of Public Health Nursing Services in the Rehabilitation of Patients

By: Thelma M. Holmes (*Supervisor of Physical Therapy, Visiting Nurse Service of Rochester and Monroe County, Rochester, N.Y.*)

In: *Nursing Outlook*. July, 1960. 8:7:380-382.

INCREASING referral by medical and related community services of handicapped persons to the public health agency for intensive physical therapy and rehabilitation training in the home emphasizes the need for dynamic and intensive rehabilitation service. The Visiting Nurse Service (VNS) of Rochester and Monroe County gives such service. It employs public health nurses, practical nurses, physical therapists, and a nutritionist. It obtains consultation from the county mental health unit and the services of an occupational therapist from another community agency. VNS offers generalized public health nursing, physical therapy, and classes for diabetics and expectant parents. Sickroom equipment is available for rental. The Service conducts an orientation of new staff, inservice education, and programs for undergraduate and graduate nursing students assigned to VNS for field instruction.

The VNS building is divided into four area nursing offices. A fifth office houses the rehabilitation staff, conducive to efficient functioning since many problems must be shared and aired to facilitate understanding and planning. Supervision is easier. The entire rehabilitation staff should keep in close touch with the generalized nursing supervisors and staff. The physical therapy supervisor is directly responsible for the total rehabilitation program; she serves as consultant to the nursing supervisors and staff and supervises care given patients by the rehabilitation staff.

The agency's medical advisory committee approves the department's emergency and standing orders. The department functions under the committee's guidance and all urgent problems are referred for committee action.

An excellent nucleus for launching a program of intensive rehabilitation is a good administrator who is open-minded, co-operative supervisors, a highly motivated physical therapy supervisor, and two or three specially trained nurses. With prescriptions not involving skills peculiar to qualified physical therapists, satisfactory treat-

ment can be given by a closely supervised rehabilitation nurse. With team relations in clear focus, we place certain selected experienced public health nurses in the rehabilitation department and call them rehabilitation nurses. Requirements are one year's service with the agency's generalized staff and an unusual interest in helping the physically handicapped. After training, these nurses confine activities to improving functional usefulness of affected and unaffected parts and give bedside nursing care and treatments only in emergency situations or when such care negates the need for another nurse's visit on the same day.

Orientation.—The rehabilitation nurse is introduced to the department's physical setup, administration, and relationship and responsibilities to other services within the agency. Her specific function and her relationship to the physical therapist are explained. Referral and intake procedures are the same as for the generalized nursing staff. With new calls, a physical therapist is assigned if orders are for electrical stimulation or detailed muscle evaluation, the rehabilitation nurse if the nursing problem is the more pressing. The rehabilitation nurse's records are adapted from those the staff nurse makes. The rehabilitation staff writes a detailed account of an initial visit. Revisit notes must include specific comments on observed changes. A special form used throughout the agency records social history and problems.

Formal Classes.—The 35 hours of formal classes include demonstration and practice under the physical therapy supervisor. Demonstration in the patients' homes often follows.

Classroom instruction includes:

1. Definition and demonstration of types of exercises—passive; active; assistive; stretching.
2. Exercises for the extremities and trunk—discussion of and practice in the range-of-joint motions; exercises including all types; and discussion, demonstration, and practice in the use of heat and massage.
3. The study of intensive stretching technics—hamstring muscle group; hip abductor and flexor muscles; heel-cord; shoulder, elbow, wrist, and fingers; trunk.
4. Selected routines for patients with diagnosis of cerebrovascular accident; fracture; amputation—especially of a lower extremity; arthritis; and multiple sclerosis.

Much class time is devoted to technics of teaching patients the skills of activities of daily living since many must relearn fundamental skills. The new nurse is

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directed through various steps used in moving about in bed, turning, sitting up, and moving to the edge. Self-care activities are taught. One-handed activities are stressed. Preamble activities are emphasized as is gait training with crutches, cane, and walker, with and without braces. Stair climbing is accented.

Field Work.—Carefully planned observation, with an experienced physical therapist or rehabilitation nurse, aids the new employee with technics. Visited are patients with cerebrovascular accidents (heat, massage, exercises, and gait training seen); lower limb amputees (exercises, gait training with pylon and prothesis); those with special gait problems, *i.e.*, how to walk unaided or with crutches and canes; those treated for maintenance of joint motion, *i.e.*, arthritics; patients learning independence through self-care.

Consultation.—In the early experience, a consultation plan is followed rigidly, so that later on consultation will be easy and automatic. There are office conferences, field visits by the physical therapy supervisor with the nurse, and supervision visits. Before a first visit to a patient, the new nurse confers with the physical therapy supervisor. A follow-up conference is held. Three supervision visits are made the first month, two the second, and one each two months thereafter, or as needed. A new rehabilitation nurse does not make initial visits on new cases for at least three months. After six months she should have adjusted and be functioning efficiently as an integral part of the department. She is then sent to the Institute of Physical Medicine and Rehabilitation, New York City, for a three or four-week course in rehabilitation technics, increasing her skills and relating theory to practice.

Generalized Nursing Staff.—A comprehensive explanation of the functions of the physical therapy and rehabilitation nursing department and some training in selected rehabilitation technics are given the new generalized staff nurse. She spends one-half day in the field visiting with a physical therapist or rehabilitation nurse. Conferences with the physical therapy supervisor review cases that may require special or intensive rehabilitation services.

Consultation visits are encouraged during the generalized staff nurse's early work experience. She may be concerned about how to teach a family easier and safer methods of handling a dependent patient or how to carry through a rehabilitation routine during the generalized nursing visit. She should be alert to situations that should be referred for other service.

The rehabilitation and the generalized nurses do not usually visit a patient on the same day, but if the two types of treatment must be given on the same day ample time is allowed for the patient to rest between visits. The rehabilitation nurse cannot do a lengthy nursing procedure in addition to her treatment, because of caseload and patient fatigue. However, she can combine simple pro-

cedures, such as a hypodermic injection, simple dressing, or blood pressure reading. The schedule is patterned to fit the patient's needs.

During the five years the department has operated as a unit office, rapid growth has been the response to demand. Through this team approach and staff preparation, care has improved and become more uniform in the type available to patients served by the Visiting Nurse Service.

Nursing Outlook, the official journal of the National League for Nursing, is published monthly by the American Journal of Nursing Company, 10 Columbus Circle, New York 19, N.Y.; subscription rate, U.S. and possessions, one year \$4.00, two years \$6.50; Canada, one year \$4.50, two years \$7.50; elsewhere, one year \$5.00, two years \$8.50; single copies, 50 cents.

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Rehabilitation in Nursing Homes

By: Florence L. Baltz, R.N. (President, American Nursing Home Association)

In: *Report on Regional Conferences on Aging*, Minneapolis, Cleveland, Kansas City, San Francisco, New Orleans, Atlanta, Baltimore, p. 114-117. 1960. 181 p. Compiled and edited by American Medical Association, Committee on Aging, 535 N. Dearborn St., Chicago 10, Ill.

ILLINOIS nursing home administrators are fortunate in being offered the program of the Rehabilitation Education Service, first of its kind in the United States. This project of the Illinois Public Aid Commission, a three-year research-demonstration program sponsored also by the U.S. Office of Vocational Rehabilitation, the Forest Park Foundation of Peoria, and the Peoria Institute of Physical Medicine and Rehabilitation, is unique in being supported by federal, state, and private foundation funds.

The program investigates: 1) rehabilitation needs among patients of nursing homes; 2) extent needs can be met by the homes' staff, with local doctors and state and community agencies co-operating; 3) type of training program that can be developed for the nursing home staff; 4) kind of teaching materials needed and how they should be put together. A group of co-operating homes, public and private, serves as research laboratories.

Requirements of applicants were approval and licensing by the state Department of Public Health; presence of at least one public aid recipient as a patient, with home continuing to accept such patients; services requested in writing by the nursing home administrator; registered or licensed practical nurse available full time during and after the training program, providing continuous

supervision for the rehabilitation nursing. A professional staff member must maintain a recreational program and have teaching ability, imagination, and ingenuity in planning activities to stir patient interest. She must be aware of community potential resources and able to develop community and public relations to avail herself of these. When the team is in the home, each staff member must attend one hour of class instruction daily. The length of the team's stay, which depends on size of home and type of staff, averages six weeks. The team returns for one day monthly for consultation.

Although the team's arrival had been discussed at the home for several months, patients, families, nurses, and physicians were not ready to accept it. The patients had received loving care and, though encouraged somewhat to help themselves, were content to have most things done for them. The program treats the patient as an individual and the team must stimulate or motivate him to want to be more independent. Newly admitted patients were easier to motivate to self-care. The others, with much encouragement, praise, and patience, slowly began to enjoy independence. Within a few days, the staff felt the challenge to really help the patients. The relatives' reluctance to have the patients bothered was dissipated in the initial interview. Nothing is done in the home without doctor's orders. At first, blanket orders for physical and occupational therapy were received. Only after several months was there an appreciable change in the physician's attitudes.

Checklists developed for each patient list only items that can be done with what we have in our homes. The patient needing more intensive care is transferred to the Peoria Institute of Physical Medicine and Rehabilitation. We now get specific orders for each patient. The Rehabilitation Center sends us patients not ready to return home or with no home.

With the program we have each year sent home five

to eight patients never expected to leave the nursing home, proving that nursing homes are not necessarily terminal. Public relations have improved so that the community responds to every need. Forty well-oriented volunteers serve our patients, with volunteers working in activities that interest them personally. The program, planned several weeks in advance, is arranged for the most benefit.

The program's cost is minimal. Material found in basements is used to construct parallel bars, exercise bars and pulleys in doorways, bicycle wheels on the wall, Canadian crutches, wheel on a block for wrist exercises, among other items. The activity director's salary is offset by less nursing care. The busy patients do not ring bells because of loneliness; they are not incontinent as much to get attention; few wish to take naps, so they sleep better at night.

The director works 40 hours a week. A time study revealed the nursing care per patient to be $2\frac{1}{4}$ hours rather than the former $2\frac{1}{2}$ hours. The sale of crafts has paid for tools and materials, games, prizes, birthday gifts, a card table, record player, and tray favors. The activity director handles this separate fund.

Each patient receives some degree of rehabilitation nursing, and 80 percent, or 32 patients, are involved in activities, leading a fuller, happier, and more meaningful life. The patients are typical of nursing homes; they have cardiovascular conditions, multiple sclerosis, paraplegia, quadriplegia, other long-term illnesses, or are senile or confused. Many have been bedfast for months and lack of proper positioning and attention had caused deformities.

The state of Washington has started a similar program. Our Illinois legislators allowed an appropriation to make this an ongoing program, instead of ending early this year. Two more teams will make a total of four teams available to give this type of care to all nursing home patients in Illinois.

The October Issue

The Article of the Month for October will be "Occupational Therapy for Motor Disorders Resulting from Impairment of the Central Nervous System" by A. Jean Ayres, A.M., OTR, Co-ordinator of the Masters' Degree Program of the Department of Occupational Therapy, University of Southern California, Los Angeles.

The Book Review of the Month will be an evaluation of *Physical Disability—A Psychological Approach*, by Beatrice Wright, Ph.D. Our reviewer is Louis S. Levine, Ph.D., Professor, Psychology Department, San Francisco State College.

Abstracts of Current Literature

This abstracting section, together with other numbered references indexed in this issue, serves as a supplement to the reference book Rehabilitation Literature 1950-1955, compiled by Graham and Mullen and published in 1956 by the Blakiston Division of McGraw-Hill Book Company, New York. An author index will be found on the last page of the issue.

AMPUTATION

633. Gordon, Everett J. (2007 Eye St., N.W., Washington 6, D.C.)

The orthopedic and prosthetic appliance clinic team. *J. Internatl. Coll. Surg.* Feb., 1960. 33:2:181-192.

Since 1949, 35 special orthopedic and prosthetic appliance clinics have been established in the U.S. and Hawaii under the guidance of the Veterans Administration. Purposes of the orthopedic team operating in the special clinic are defined. Duties of other members of the clinic team—the orthopedic surgeon, physical therapist, prosthetic representative (a VA employee), prosthetist, and occupational therapist are discussed, as are prosthetic problems of the upper and lower extremity. Research, an important function of the clinic team, is reviewed briefly. Three examples of "problem cases" illustrate the value of prosthetic clinic teamwork. Dr. Gordon is director of the clinic established in Washington, D.C.

AMPUTATION—MEDICAL TREATMENT

634. Gillis, Leon (Queen Mary's (Roehampton) Hosp., Roehampton, London, S.W. 15, England)

Amputations and artificial limbs. *Annals Royal Coll. Surg. England.* Jan., 1960. 26:24-56.

In this lecture delivered at the Royal College of Surgeons of England in 1959, the writer discusses in some detail the surgical technics in amputations of all types, indications for surgery, site of amputation, and the objectives for surgery where use of a prosthesis is anticipated. A statistical analysis of the reasons for arm or leg amputations in 2,215 patients seen at the Limb-Fitting Centre, Queen Mary's Hospital, during 1958 is included. Article is illustrated.

AMPUTATION (CONGENITAL)

635. Swanson, Alfred B. (1810 Wealthy St., S.E., Grand Rapids 6, Mich.)

Unusual anomalies in the upper extremity. *Orthopedic & Prosthetic Appliance J.* June, 1960. 14:2:47-51.

In same issue: The story of Brett Cunningham, H. P. Barghausen. p. 79-80.

As consultant to the Area Child Amputee Center, Michigan Crippled Children Commission, Dr. Swanson is well acquainted with the special problems in prosthetic fitting of children presenting unusual conditions. Three case histories from the files of the Center illustrate rehabilitation of children requiring bilateral prostheses. Photographs.

Mr. Barghausen (J. E. Hanger Co., Philadelphia, Pa.) reports the fitting of a 14-month-old boy with a prosthesis for congenital absence of the right leg below the knee.

APHASIA

636. Critchley, Macdonald (National Hospital, Queen Square, London, England)

Jacksonian ideas and the future, with special reference to aphasia. *Brit. Med. J.* July 2, 1960. 5191:6-12.

In his Centennial Oration of the Institute of Neurology given at County Hall, London, in June, 1960, Dr. Critchley discussed the ideas and clinical methods of Hughlings Jackson and their influence on the discipline of neurology. Biographical material shows how Jackson's interest turned to the field of neurology and the area of disordered speech. New tools for research in aphasiology are discussed by Dr. Critchley, as are eight problems requiring research before questions can be answered. These problems, he believes, are of the sort that would have intrigued Jackson and his ideas are sure to stimulate investigations seeking solutions.

APHASIA—PSYCHOLOGICAL TESTS

637. Doehring, Donald G. (Indiana Univ. Med. Center, Indianapolis, Ind.)

MMPI performance of aphasic and nonaphasic brain-damaged patients, by Donald G. Doehring and Ralph M. Reitan. *J. Clinical Psych.* July, 1960. 16:3:307-309.

Findings of the study led to the conclusion that both aphasic and nonaphasic brain-damaged patients manifest personality disturbances similar to those of nonbrain-damaged patients with neurotic symptoms. The study does not attempt to explain why brain-damaged patients, who are generally considered to be rather apathetic, should be more highly motivated to make socially acceptable responses than are nonbrain-damaged patients with pronounced neurotic symptomatology. Results support Wepman's contention that aphasic patients tend to manifest personality disturbances in addition to language disturbance directly associated with aphasic symptoms. It is suggested that such disturbances are characteristic of brain-damaged patients in general, irrespective of the presence or absence of aphasic symptoms.

See also 653.

ARCHITECTURE (DOMESTIC)

638. Winston, Jack A.

Concepts of residential care; an architectural guide. New York, United Cerebral Palsy Assns. of New York State (1960). 49 p. illus.

The author, an associate member of the American Institute of Architects, has prepared a guide for use in establishing residential services for the cerebral palsied adult. The standards can also be adapted to facilities serving persons with other disabilities and of other age

groups. A brief examination of the medical, social, and psychological problems of the cerebral palsied, to determine their specific needs as related to the residential facility, has resulted in architectural recommendations for a prototype building. The unit is flexible enough to be constructed anywhere in the country. Special thought has been given to architectural details that would create an emotionally stable environment. Capacity of the unit provides for 20 persons, two-thirds of whom would be housed in double rooms, the remainder in single rooms.

Available from United Cerebral Palsy Associations of New York State, 220 W. 42nd St., New York 36, N.Y., at \$1.00 a copy.

BLIND

639. Drake, T. S. (*Royal Natl. Institute for the Blind's Rehabilitation Centre, Torquay, England*)

Rehabilitation of the blind, by T. S. Drake and Isabel A. Potts. *Occupational Ther.* June, 1960. 23:6:21-28.

As head of the rehabilitation center for newly blinded persons mainly between the ages of 18 and 55, Mr. Drake discusses some of the modern problems associated with blindness and administration of the program at Torquay. Training at the center is essentially prevocational; much is also accomplished in restoring self-confidence to clients.

Miss Potts, a former physical therapist at Manor House, Torquay, and currently head occupational therapist at Harrogate Royal Bath Hospital, discussed occupational therapy with blind persons, methods of treatment, and the type of activities used in training.

BLIND—PARENT EDUCATION

See 623.

CEREBRAL PALSY—MEDICAL TREATMENT

640. Marsh, Henry O. (3244 E. Douglas St., Wichita 8, Kan.)

Active treatment of cerebral palsy. *J. Kan. Med. Soc.* Nov., 1959. 60:12:481-485, 504.

A report of the cerebral palsy methods at the Institute of Logopedics, Wichita, Kansas, answering questions most frequently asked by physicians and supplying information on the sociomedical problems of the cerebral palsied child. Although the Institute is for the speech handicapped, a special clinic for the cerebral palsied has been in operation since 1948.

CEREBRAL PALSY—PERSONNEL

See 625.

CEREBRAL PALSY—SPECIAL EDUCATION

641. New York. State Education Department. Bureau for Handicapped Children

A curriculum focus for the child with cerebral palsy and mental retardation; report of the Metropolitan Regional Group III. . . . New York, United Cerebral Palsy Assns. of New York State, 1960. 49 p. illus.

Under the New York State Education Department's inservice training program for educators of cerebral palsied children, 10 regional study groups met periodically to discuss solutions for specific problems related to

education of the cerebral palsied. This report of Study Group III focuses attention on communication skills and physical-personal self-reliance. Programs for home instruction and parent counseling, for children at the pre-nursery school, nursery school, and kindergarten-primary levels, for the older cerebral palsied mentally retarded child, and for the adolescent and adult individual are discussed. Questions for further study and consideration are given in conclusion. Appendixes contain such practical aids as an outline of the scope of the report, the educational program and the facilities needed, and examples of activities and equipment useful in teaching the cerebral palsied.

Dr. Joseph Fenton, Special Assistant to the New York State Interdepartmental Health and Hospital Council, is Co-ordinator of the Regional Study Groups. Dr. Frances P. Connor and Dr. Mary E. Harnett served as co-chairmen of this particular publication. Available from United Cerebral Palsy Associations of New York State, 220 W. 42nd St., New York 36, N.Y., at 25¢ a copy.

CHILDREN—GROWTH AND DEVELOPMENT

See 623; 624.

CHRONIC DISEASE

642. Ryder, Claire F. (*U.S. Public Health Service, Washington 25, D.C.*)

A modern-day challenge—disability. *J. Am. Med. Women's Assn.* July, 1960. 15:7:689-692.

In her inaugural address presented as president at the annual meeting of the American Medical Women's Association in 1960, Dr. Ryder stressed the role of women physicians in the field of chronic disease and its preventive aspects.

CHRONIC DISEASE—ILLINOIS

643. Schmitz, Henry L. (55 E. Washington St., Chicago 2, Ill.)

Our aging population and the problem of chronic illness in Chicago, by Henry L. Schmitz and Edna Nicholson. *Ill. Med. J.* Apr., 1960. 117:4:229-230.

Data from articles by Dr. Schmitz and Miss Nicholson that appeared in a recent publication of the Institute of Medicine of Chicago's Central Service for the Chronically Ill (see *Rehab. Lit.*, June, 1960, #413) are presented briefly to show the extent of the problem of chronic illness in Chicago. Present types of care available and the estimated expenditures for services are discussed.

See also 632.

CHRONIC DISEASE—INSTITUTIONS

See 629.

CHRONIC DISEASE—PERSONNEL

644. McCord, Vera (*Washington State Dept. of Health, 214 General Administration Bldg., Olympia, Wash.*)

Rehabilitation Education Service in Washington. *Chronic Illness Newsletter.* June, 1960. 11:3:(2-3).

Passage of the Washington Nursing Home Licensing Law in 1951 placed responsibility on the State Depart-

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ment of Health for inspection and licensing of homes. An educational program to improve nursing home standards has been implemented with the Division of Vocational Rehabilitation and the Department of Public Assistance co-operating in the program. Purposes and administration of the Rehabilitation Education Service are discussed. The plan is similar to one in operation in Illinois under the Illinois Public Aid Commission (see *Rehab. Lit.*, May, 1959, #381).

645. Park, Wilford E. (420 Fourth Ave., S., Minneapolis 15, Minn.)

Rehabilitation care in nursing homes, by Wilford E. Park and Mildred I. Moe. *Public Health Rep.* July, 1960. 75:7:605-613.

Dr. Park, chief of occupational health service, and Mrs. Moe, nurse adviser of rest homes, Minneapolis Health Department, have been responsible for the surveillance and improvement program in nursing homes since its inception several years ago. This article describes in some detail a one-year demonstration project conducted by the Minneapolis Health Department, with the co-operation of the Kenny Institute. An educational program for nursing home administrators and their nursing staffs was provided and rehabilitation technics demonstrated. Twelve nursing homes participated on a competitive basis, with a citation awarded to the home making the most improvement in each competition period. Results are analyzed and the benefits assessed.

CHRONIC DISEASE—SURVEYS

646. Goldmann, Franz (Harvard School of Public Health, Boston, Mass.)

A study of chronically disabled clients, by Franz Goldmann and Ethel A. Wilson. *Soc. Casework.* July, 1960. 41:7:354-360.

Findings from a research project conducted under the auspices of the Council of Jewish Federations and Welfare Funds, New York City, are presented. Information on a total of 232 clients of four Jewish family service agencies and the services rendered reveals the particular needs of such clients and what provisions for them are being made by agencies under voluntary auspices.

CHRONIC DISEASE—SURVEYS—NEW YORK

647. Niagara Falls Council of Social Agencies

The changing pattern of illness; planning for the chronically ill in Niagara County, survey report of . . . New York, State Charities Aid Assn., 1960. 39 p. map, charts.

This report is a condensation of findings of a two-year comprehensive study made by physicians, agencies of Niagara County, and volunteers from the community. Hospital, nursing home, and home care were investigated and the economic impact of long-term care scrutinized. Survey methods are explained. The detailed recommendations for improving over-all community care of the chronically ill call for immediate action and provide long-range goals.

Available from Council of Social Agencies, P.O. Box 406, Niagara Falls, N.Y.

COLOSTOMY

648. QT Inc., Boston (c/o The Medical Foundation, 227 Commonwealth Ave., Boston 16, Mass.)

Manual for ileostomy patients; 4th ed. rev. Boston, QT Inc., 1960. 94 p. illus. \$2.00.

This manual, greatly enlarged since the third edition in 1955, presents current information on the daily management of ileostomy. Much of the material may be useful to those with ileal bladder or transverse colostomy since they, like ileostomists, must permanently wear an appliance. A new feature of this edition is the section containing 23 photographs of ileostomy equipment with the source of supply. A glossary of terms concludes the manual.

EMPLOYMENT—GREAT BRITAIN

See 626.

EMPLOYMENT—INDIA

See 678.

HARD OF HEARING—PARENT EDUCATION

649. American Academy of Ophthalmology and Otolaryngology (15 Second St., S.W., Rochester, Minn.)

Suggestions to the parents of a hard of hearing child, by Gloria Hoversten and Jacqueline Keaster. Rochester, Minn., The Academy, 1959. (26) p. illus.

A parent education pamphlet to explain how the hard of hearing child learns to talk and how he can be helped to acquire speech and make better use of his hearing. The bibliography includes additional books for parents, books and records the child may enjoy, and a list of agencies where parents may write for information. A pamphlet titled *Suggestions to the Parents of a Deaf Child*, by the same authors, was published by the Academy in 1958 and is similar in format to the latter publication.

HEART DISEASE—PHYSICAL THERAPY

650. Evans, Sybil M. (School of Physiotherapy, Guy's Hospital, London, England)

Physiotherapy in surgical conditions of the heart. *Physiotherapy.* July, 1960. 46:7:193-197.

A paper based on a lecture delivered at the World Congress for Physical Therapy in 1959. It is especially important in caring for patients that the physical therapist collaborate closely with the surgeon and nursing staff. A brief outline of postoperative physical therapy is included.

HEART DISEASE—SOCIAL SERVICE

651. Callaghan, Ann (Social Service Dept., West Jersey Hosp., Camden, N.J.)

Casework services to parents of children with cardiac disabilities. *Public Health News*, N.J. State Dept. of Health. July, 1960. 41:7:244-247.

The social worker in the cardiac service can enable parents of the child with heart disease to face realistically the many decisions they must make in regard to surgical treatment, meeting the high costs of care, and day-to-day management of the child. Helping parents relate positively

to the services offered the child is the social worker's main objective in such cases.

652. Goldner, Rose (*Mrs. Kyle, V.A. Hospital, Brooklyn, N.Y.*)

A group approach to the cardiac patient, by Rose Goldner and Eleanor H. Kyle. *Soc. Casework*. July, 1960. 41:7:346-353.

Describes an experimental group therapy program for hospitalized patients with myocardial infarction. Techniques of the group process and brief descriptions of the social situations of the six participating patients are included. The group approach was found effective in dealing with patient resistance found in individual casework treatment.

HEMIPLEGIA—PHYSICAL THERAPY

See 688.

HEMIPLEGIA—PSYCHOLOGICAL TESTS

653. Hirschenfang, Samuel (*Kings County Hospital Center, Brooklyn, N.Y.*)

Comparison of WAIS scores of hemiplegic patients with and without aphasia. *J. Clinical Psych.* July, 1960. 16:3:(351).

Findings of an investigation supported by a grant from the National Institutes of Health suggest that left hemiplegics without aphasia may present greater rehabilitation problems than right hemiplegics, with or without aphasia. Left hemiplegics without aphasia showed consistently poorer performance on a test of intelligence than aphasic or nonaphasic right hemiplegics.

HOMEBOUND—PROGRAMS

See 628; 631.

LARYNGECTOMY

654. Snidecor, John C. (*Dept. of Speech, Univ. of California at Santa Barbara, Calif.*)

How effectively can the laryngectomee expect to speak? Norms for effective esophageal speech, by John C. Snidecor and E. Thayer Curry. *Laryngoscope*. Jan., 1960. 70: 1:62-67.

Very little direct information is available in the literature concerning how effectively the laryngectomee can expect to speak. This report of a study that investigated the rate and frequency characteristics of superior esophageal speech offers realistic norms for use in evaluating performance of the laryngectomee. Speech samples of adequate length were used; norms for rate, breathing, and frequency have already been established, using the identical samples with normal and superior speakers. The results were considered conservative and reliable but are far less optimistic than predictions for success made in recent popular literature.

MENTAL DEFECTIVES

655. Johnesse, Adaline (*Off. of Voc. Rehabilitation, Washington 25, D.C.*)

Rehabilitating the mentally ill: I. Growth of state-federal program; II. Research in rehabilitation. *Rehab. Record*. Mar.-Apr. & May-June, 1960. 1:2 & 3. 2 pts.

The second and concluding part of this article dealing with vocational rehabilitation services for the mentally ill summarizes a few of the 27 research projects in this area that receive support from the Office of Vocational Rehabilitation. Information on rehabilitation research fellowships available under the Office's program is included. (For Part I, see *Rehab. Lit.*, July, 1960, #526.)

MENTAL DEFECTIVES—BIOGRAPHY

656. Kanner, Leo (*Univ. of Minnesota, Minneapolis 14, Minn.*)

Itard, Seguin, Howe; three pioneers in the education of retarded children. *Am. J. Mental Deficiency*. July, 1960. 65:1:2-10.

The movement for the care of mental defectives owes much to these three men whose lives and accomplishments Dr. Kanner reviews briefly. Short bibliographies of their published works and of biographical data are included.

MENTAL DEFECTIVES—DIAGNOSIS

657. Sievers, Dorothy J. (*Columbus State School, 1601 W. Broad St., Columbus 16, Ohio*)

The Differential Language Facility Test and electroencephalograms of brain-injured mentally retarded children, by Dorothy J. Sievers and Carl M. Rosenberg. *Am. J. Mental Deficiency*. July, 1960. 65:1:46-50.

A previous study by Miss Sievers (see *Rehab. Lit.*, June, 1959, #498) reported differences found between performance of brain-injured and nonbrain-injured children on the Differential Language Facility Test. The present investigation considered whether the brain-injured differ among themselves. EEG tracings of 50 brain-injured mentally retarded children were classified in four groupings: 1) grand mal pure, 2) grand mal and petit mal mixed, 3) hypothalamic, and 4) slowing. Scores of the four groups, when compared, showed significant differences between groups on the two subtests involving the audiovocal channel on the integrational and grammatical levels. Findings suggest that brain-injured children with EEG tracings of Grand Mal Mixed with Petit Mal discharges might have more difficulty in this area of language than brain-injured children with other types of EEG's. Added evidence that brain-injured children are not a homogeneous group in behavioral reactions is given.

MENTAL DEFECTIVES—EMPLOYMENT

See 686.

MENTAL DEFECTIVES—ETIOLOGY

658. Sterling, Theodor D. (*Dept. of Preventive Medicine, Univ. of Cincinnati Coll. of Medicine, Cincinnati, Ohio*)

Seasonal variations in the birth of the mentally deficient? *Am. J. Public Health*. July, 1960. 50:7:955-965.

A critical analysis of an article by Drs. Hilda Knobloch and Benjamin Pasamanick, published in the *Am. J. Public Health* in Sept., 1958 (see *Rehab. Lit.*, Nov., 1958, #1220). Validity of the statistical tests and the serious sources for bias in the sample population of the original study were examined. The writer contends that one

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should not insist on answering biological questions solely by statistical manipulations.

MENTAL DEFECTIVES—INSTITUTIONS

659. Lyle, J. G. (*Fountain Hospital, London, England*)

The effect of an institution environment upon the verbal development of imbecile children: II. Speech and language; III. The Brooklands residential family unit. *J. Mental Deficiency Research*. June, 1960. 4:1:1-23.

The Dec., 1959, issue of the *Journal* carried Part I of Dr. Lyle's three-part article; in it he compared the verbal intelligence of institutionalized imbecile children with that of imbeciles of similar nonverbal IQ, living at home and attending day schools. Retardation in verbal intelligence in institutionalized children was thought to be due to long residence. Part II compares the same two groups on *ad hoc* verbal tests designed to measure different aspects of speech and language. Imbeciles at the institution were lower in verbal ability than those in day schools, whether they were children with mongolism or without. Testing and evaluation procedures are explained. Part III reports an experimental project to discover whether verbal retardation attributed to institutionalization could be offset in a differently organized social environment with smaller numbers of children and different methods of care. (Dr. J. Tizard's article on this research project was annotated in *Rehab. Lit.*, June, 1960, #427.) On the average over the 12-month period, children at Brooklands improved about 4 months of verbal MA over a control group of children who remained at Fountain Hospital.

MENTAL DEFECTIVES—MENTAL HYGIENE

660. Boston, John A., Jr. (*Austin Community Guidance Center, Austin, Texas*)

The defective child, his family, and the use of a child guidance clinic. *Am. J. Public Health*. June, 1960. 50: 6:799-802.

Various benefits to the child and to the family can result from direct casework to the parents and from psychiatric study and testing of the child in the intermediate or high-grade defective range. Such services can be provided by the child guidance clinic. The clinic should not rigidly exclude children known to be mentally defective or brain-injured when certain criteria are taken into consideration.

MENTAL DEFECTIVES—PARENT EDUCATION

661. Mandelbaum, Arthur (*Menninger Clinic, Topeka, Kan.*)

The meaning of a defective child to parents, by Arthur Mandelbaum and Mary Ella Wheeler. *Soc. Casework*. July, 1960. 41:7:360-367.

Two psychiatric social workers analyze attitudes of parents of defective children as revealed during diagnostic study at Menninger Clinic's Children's Service. They suggest that parents' "shopping" for a diagnosis may sometimes reflect resistance and rebellion that are healthy adaptive mechanisms and not an indication of their inability to face misfortune.

MENTAL DEFECTIVES— PSYCHOLOGICAL TESTS

662. Dingman, Harvey F. (*Pacific State Hospital, Box 100, Pomona, Calif.*)

Factor analysis of a magazine interest test, by Harvey F. Dingman (and others). *Am. J. Mental Deficiency*. July, 1960. 65:1:59-63.

A report of an exploratory investigation of the possibilities of typifying individuals by their magazine choices was attempted with 281 patients. Five magazines of divergent kinds of interest—pictorial news and entertainment, adventure and crime, home and travel, the male physique, and nudist—were used. Analysis of the data identified factors of general sex interest, sensationalism, conformity, and masculine interest demonstrated by the patients observed. Ability to identify various interests may have significance for evaluating later adjustment. Such measures of personality are difficult to obtain for use with the mentally retarded; this is one of a number of behavior measures of social behavior collected by the Population Movement Study Group.

663. House, Betty J. (*Univ. of Connecticut, Storrs, Conn.*)

Visual discrimination learning and intelligence in defectives of low mental age, by Betty J. House and David Zeaman. *Am. J. Mental Deficiency*. July, 1960. 65:1:51-58.

Conflicting evidence regarding the relationship between intelligence and ability to learn led to the present investigation of the relationships between MA and IQ scores and learning rate in a group of mentally defective children of low MA (2-6 years). The learning task was a simple two-choice color-form discrimination of the type used in studying animal intelligence. Findings led to the conclusion that MA and IQ were independently related to learning. An alternative interpretation offered is that the individual differences observed in performance on the visual discrimination task were those of attention rather than learning. 21 references.

664. Klausmeier, Herbert J. (*Dept. of Education, Univ. of Wisconsin, Madison 6, Wis.*)

Relationships among physical, mental, achievement, and personality measures in children of low, average, and high intelligence at 125 months of age, by Herbert J. Klausmeier, John Check, and John Feldhusen. *Am. J. Mental Deficiency*. July, 1960. 65:1:69-78.

Two previous reports of this research project were listed in *Rehab. Lit.*, Mar., 1959, #242, and Aug., 1959, #663. The first article discussed design of the study and the second analyzed data on children at 113 months. This concluding article records and analyzes data on children of low, average, and high intelligence (40 in each group). In relation to the specific hypotheses tested, it was found that a low level of physical development does not accompany low achievement in either arithmetic or reading nor does uneven physical development. Average IQ children show greater within-child variability in grip, IQ, reading, arithmetic, and language than either the high or low IQ groups. Within-child variability in reading, arithmetic, and language is the same among the IQ groups.

See also 673; 674.

MENTAL DEFECTIVES—SPECIAL EDUCATION

See 630.

MENTAL DEFECTIVES— SPECIAL EDUCATION—DELAWARE

665. Jubenville, Charles P.

Day care centers for severely retarded children in Delaware has led to unexpected dividends for everyone. *Nursing Outlook*. July, 1960. 8:7:371-375.

The program in Delaware is the first of its kind in the country, as far as is known, that is entirely state supported through public tax funds. The supervisor of the program, administered from an institutional setting, describes activities and administration of four community day care centers currently operating. The nurse's role is very important.

MENTAL DEFECTIVES— SPECIAL EDUCATION—ILLINOIS

666. Tisdall, William J. (*Institute for Research on Exceptional Children, Univ. of Illinois, Urbana, Ill.*)

A follow-up study of trainable mentally handicapped children in Illinois. *Am. J. Mental Deficiency*. July, 1960. 65:1:11-16.

A follow-up report on 126 children enrolled five years previously in special public school classes in Illinois for the trainable mentally handicapped; all but five of the group had IQ's below 50. Findings of the study have implications for curriculum planning, for the organization of classes, for postschool accommodation within the community, and for parent counseling and parent organizations. (For a previous report of the original study project initiated by the Illinois State Department of Public Instruction, see *Rehab. Lit.*, July, 1955, #708.) This paper is an abstract of a master's thesis (Univ. of Illinois); the follow-up study was a co-operative research project of the Institute for Research on Exceptional Children and the Illinois State Department of Public Instruction.

MENTAL DISEASE—NEW YORK

667. Fisher, Saul H. (124 E. 65th St., New York 21, N.Y.)

Rehabilitation of the mental hospital patient; the Fountain House program, by Saul H. Fisher, John H. Beard, and Victor Goertzel. *Internat. J. Soc. Psychiatry*. Spring, 1960. 5:4:295-298.

Origins of Fountain House go back to the immediate postwar period but it was not until 1948 that formal organization occurred. Purely a social club until 1958, it now has an expanded professional staff that supervises small group activities and the activities center program. Seven such small groups are located in different areas of New York City (one in New Jersey). Patients become active participants in these social groups with facilities for meeting provided by the local community. In addition to the activities center program located at Fountain House, a day program to enable patients to regain work skills and work tolerance is sponsored by the New York State Department of Mental Hygiene. A clinical example shows the program's effectiveness.

MENTAL DISEASE—EMPLOYMENT

668. Bieliauskas, Vytautas J. (*Dept. of Psychology, Xavier Univ., Cincinnati 7, Ohio*)

The attitude of industrial employers toward hiring of former state mental hospital patients, by Vytautas J. Bieliauskas and Harvey E. Wolfe. *J. Clinical Psych.* July, 1960. 16:3:256-259.

Findings of a previous study made in 1958 (see *Rehab. Lit.*, Sept., 1958, #1012, and Nov., 1958, #1233) revealed a small sample of employers in the Metropolitan Boston area (52) willing to hire former mental patients. The present study reports findings of a survey of attitudes of a larger sample (251) of manufacturing firms in a Midwestern city. Only a minority of employers objected to hiring former state mental hospital patients; the majority showed a highly positive attitude toward their employment.

669. Jones, Maxwell (*Oregon State Hosp., Salem, Ore.*)

Social rehabilitation with emphasis on work therapy as a form of group therapy. *Brit. J. Med. Psych.* 1960. 33:67-71.

A former director of the Social Rehabilitation Unit, Belmont Hospital, Sutton, England, describes the organization of five work groups at the Hospital, administration of the workshop program, and use of workshops as group therapy. Production work as therapy is reviewed. Dr. Jones believes work therapy should be complementary to formal treatment groups. Social aspects of treatment and patient management should not be confused with more specific treatment methods.

MENTAL DISEASE—PROGRAMS

670. Rosner, S. Steven (*Maryland Assn. for Mental Health, 2100 N. Charles St., Baltimore 18, Md.*)

Aftercare services for the mental hospital patient; a survey of 10 state mental hospitals in Pennsylvania. *Mental Hygiene*. July, 1960. 44:3:417-425.

A 1959 survey indicated that hospitals and communities are beginning to work together to provide aftercare services for ex-mental patients. However, the hospitals surveyed reported almost no contact with about 75 percent of furloughed patients. Specific aftercare programs are suggested to facilitate psychiatric, social, and vocational rehabilitation of released patients but such programs will need to be expanded if hopes of reducing patient populations are to be realized.

MUSCULAR DYSTROPHY

See p. 270.

OLD AGE

671. Larson, Dale C.

Full circle—and more; working with the older age group. *J. Rehab.* May-June, 1960. 26:3:15-19, 34-35.

Rehabilitation should not be provided on the basis of age, employability, or type of handicap but should be available to all persons throughout the entire lifespan. Three factors in successful rehabilitation—good selection, adequate motivation on the part of both the patient and those involved in his rehabilitation program, and, last,

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follow-up to maintain gains—apply to geriatric programs in the same manner as to other age groups. Mr. Larson, director of the Geriatrics Rehabilitation Program for Illinois, shows how rehabilitation technics can meet the total needs of older persons.

PARAPLEGIA

672. Hastings, John E.

A study of the paraplegic patient. Toronto, Canada, Workmen's Compensation Board (1959). 71 p. tabs.

A detailed statistical study sponsored by the Workmen's Compensation Board of Ontario in an attempt to evaluate results of the medical treatment and the physical, social, and vocational rehabilitation services for paraplegic and quadriplegic patients served by the Board. Data are included on patient characteristics, type of employment at time of injury, primary cause of death, general medical and treatment aspects, influence of rehabilitation services on the development of self-care and locomotion, medical care costs, and employment status following rehabilitation.

The study is available to persons or associations directly connected with the problem of the paraplegic patient. Request from Workmen's Compensation Board, 90 Harbour St., Toronto 1, Ont., Canada.

PEDIATRICS

See 624; 631.

PHYSICAL EFFICIENCY

673. Berkson, G. (*Maudsley Hospital, London, England*)

An analysis of reaction time in normal and mentally deficient young men: I. Duration threshold experiment; II. Variation of complexity in reaction time tasks. *J. Mental Deficiency Research*. June, 1960. 4:1:51-67.

Previous reaction time studies using mentally deficient persons as subjects have consistently demonstrated a positive relationship between speed and IQ. The experiment reported in Part I measured the length of time a stimulus must be exposed in order to be correctly identified. Subjects were normal and familial mentally deficient adolescent boys with no evidence of brain abnormality. Comparison of visual duration threshold in the two groups was made. No relationship was demonstrated between IQ and the length of time a stimulus must be exposed to be recognized. Part II reports still another experiment comparing visual reaction time of 16 familial mentally deficient and 15 normal adolescent boys on three tasks varying in complexity. As in previous studies, the retarded were slower than the normals; more complex tasks elicited slower responses than did simple tasks. No relationship between IQ and the amount of slowing was demonstrated, however.

These reports formed part of the author's doctoral dissertation (George Peabody College for Teachers). Dr. Berkson is currently a postdoctoral research fellow at the Medical Research Council Unit, Maudsley Hospital, London.

PSYCHOLOGICAL TESTS

674. Malpass, Leslie F. (*Southern Illinois Univ., Carbondale, Ill.*)

The utility of the Progressive Matrices (1956 edition) with normal and retarded children, by Leslie F. Malpass, Ronald Brown, and Donald Hake. *J. Clinical Psych.* July, 1960. 16:3:(350).

Results of this research study suggest that the 1956 revision of the Progressive Matrices differentiates retarded and normal children practically as well as IQ scores; the Matrices also demonstrate difference-trends between institutionalized and noninstitutionalized retarded children of the same order as IQ scores. Ages of the children studied ranged from 8 to 13. The revised form of the test appears to offer possibilities as a screening device for children in this age range.

PUBLIC HEALTH NURSING

See 631.

REHABILITATION

675. Austlid, Olav (*321 E. 42nd St., New York 17, N.Y.*)

Special problems in total medical care of the handicapped patient after hospital discharge; two case reports. *Arch. Phys. Med. and Rehab.* July, 1960. 41:7:308-310.

Two case histories of patients of the poliomyelitis ward, Hospital for Special Surgery, New York City, are cited in illustrating economic, vocational, social, and psychological problems that must be solved. Adaptations in the home and the provision of equipment to aid the patient in achieving maximum independence are necessary. The physician should be aware of community resources and the value of teamwork in meeting total needs of the physically handicapped discharged from the hospital.

676. National Rehabilitation Association (*1025 Vermont Ave., Washington 5, D.C.*)

NRA and rehabilitation; a summary report of findings at Executive Committee Retreat . . . March 15-17, 1959. *J. Rehab.* May-June, 1960. 26:3:8-11, 38-41.

This policy statement represents the combined view of NRA members and leaders in the field of rehabilitation concerning the role of the Association in the development of rehabilitation programs for the disabled. The Executive Committee authorized publication of the report in the hope that it might provide a base for the development of sound policies and the starting point for consideration of future programs. Available as a reprint from the Association at 10¢ a copy.

REHABILITATION—CANADA

677. Gray, C. G. (*Charles Camsell Hosp., Edmonton, Canada*)

Some orthopaedic problems in Indians and Eskimos. *Canad. J. Occupational Ther.* June, 1960. 27:2:45-50.

A brief review of the history of the Indian Health Services in Canada that has, since 1945, provided medical care to both Indians and Eskimos. Administration of services in the Foothills Region, centered in Edmonton, is described. Experiences at the Charles Camsell Hospital, a diagnostic and treatment center, are unique because of the medical problems of the natives. Bracing and the provision of prostheses following amputation, leg length discrepancies, congenital dislocation of the hip, and muscu-

lar paralysis call for adaptations. Early referral of cases has also been a problem but once hospitalized both races appear to tolerate often long periods of hospitalization.

REHABILITATION—INDIA

678. Indian Conference of Social Work

Services for the physically handicapped. *Indian J. Soc. Work.* Mar., 1960. 20:4:86-104.

Addresses presented at a special section devoted to discussion of services for the handicapped are included in the report of the Eleventh National Conference of Social Work, held in Hyderabad, India, December, 1959. The entire issue of the *Journal* is given over to the report.

Contents: Chairman's address, Smt. Fathema Ismail.—The employment potential of the physically handicapped, Smt. Kamala Nimbkar.—Assessment of need in the present set up, Shri S. A. Qadri.—The handicapped in the nation's economy, Smt. Fathema Ismail.—Recommendations.

679. Mazarello, Theodore G. (Tata Institute of Social Sciences, Chembur, Bombay, India)

Social services in the Third Five Year Plan. *Indian J. Soc. Work.* Dec., 1959. 20:3:209-214.

In same issue: Welfare services for the aged and infirm, C. A. Amesur. p. 157-162.—The social component in medical care, P. I. George. p. 169-172.

Social welfare and social services recommended for inclusion in India's Third Five Year Plan are set forth; child welfare should take priority but welfare of the handicapped is also stressed. These recommendations, if adopted, would result in the Third Plan differing from the first two in which top priority was given to economic interests—agriculture and heavy industry.

Dr. Amesur's article points out problems of the aged and infirm caused by changing sociological conditions. He offers suggestions for welfare services to provide social security. The problems are complicated by the fact that most of the aged are to be found in rural areas, making the provision of aid more difficult.

Mr. George (*Kasturba Med. College, Mangalore, India*) emphasizes the need for recognition of the medical social worker's role in modern medical practice. The social aspects of illness have not been fully understood in India. The concept of rehabilitation demands inclusion of the social worker as a member of the treatment team.

REHABILITATION—ADMINISTRATION

680. Ropchan, Alexander (Welfare Council of Metropolitan Chicago, 123 W. Madison St., Chicago 2, Ill.)

The need of integrating the community rehabilitation agency and disciplines. *J. Rehab.* May-June, 1960. 26:3:4-7, 45-47.

As associate director of the Welfare Council of Metropolitan Chicago, Mr. Ropchan is well aware of the great need for community planning through integrated action of all community agencies. As services for the handicapped increase in scope, the inefficiencies of inadequate integration become more apparent. Obstacles to integration, conditions for co-operation, and principles and examples of community planning in rehabilitation are discussed. This paper was presented at the National Rehabilitation Association's Region V annual conference in Milwaukee

in April, 1960. (For an account of the action-research plan for Chicago, see *Rehab. Lit.*, July, 1960, p. 235.)

REHABILITATION—HISTORY

681. Rehabilitation Record. May-June, 1960. 1:3:3-24

Partial contents: The open door (editorial), Mary E. Switzer.—40th Anniversary; a tide in the affairs of men.—Highlights of vocational rehabilitation legislation.—State leaders in the state-federal program, John A. Kratz.—Development of programs for the blind, Peter J. Salmon.—Forty years in rehabilitation of youth, Henry H. Kessler.—Oldest rehabilitants.

Progress during four decades of vocational rehabilitation is reviewed in the articles commemorating the 40th anniversary of the passing of Public Law 236 in 1920.

REHABILITATION—PERSONNEL

682. National Rehabilitation Association (1025 Vermont Ave., Washington 5, D.C.)

Policy on rehabilitation personnel training. *J. Rehab.* May-June, 1960. 26:3:26-27.

Prepared by the Professional Standards and Relationships Committee and approved by the Association's Board of Directors, this statement recommends expansion and development of more comprehensive rehabilitation training programs in institutions of higher learning, greater use of inservice training, more functionally sound curricula at both the undergraduate and graduate level, more selectivity in student trainees, internship training, and increased grants supporting trainees and research. Also considered were higher salary levels and better employment standards. Reprints of the article are available from the Association at 10¢ a copy (20 percent discount on orders of 10 or more).

See also 631; 632; 644; 645; 687.

REHABILITATION CENTERS—ADMINISTRATION

See p. 280.

SHELTERED WORKSHOPS—ADMINISTRATION

683. Massie, William A. (Off. of Voc. Rehabilitation, Washington 25, D.C.)

Implications of workshop standards. *Rehab. Record.* May-June, 1960. 1:3:31-33.

The need for workshop standards was clearly defined and recognized at a national institute on workshops held in Bedford Springs, Pa., in April, 1958. Subsequently a National Institute on Workshop Standards was established to draft tentative classification and evaluation guidelines. Numerous studies and conferences during the past two years have resulted in a set of standards, soon to be published, covering program of services, administration, staff, facilities, and community relations. Groups in the workshop field will be interested in Mr. Massie's interpretation of the implications of the published standards.

See also 685.

SPECIAL EDUCATION—PERSONNEL

See 625; p. 285.

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SPEECH CORRECTION

684. George, Ella Mary (*V.A. Hospital, Oklahoma City, Okla.*)

Communications therapy program in a Veterans Administration hospital, by Ella Mary George, John L. Boland, Jr., and Elizabeth M. Kevin. *J. Am. Med. Women's Assn.* July, 1960. 15:7:678-681.

A physiatrist, a consultant in speech pathology, and a social worker assigned to the physical medicine and rehabilitation service of a VA hospital discuss their individual roles and the administration of a communications therapy program. Referrals are made early in the patient's illness. Both group and individual therapy are available. Patients are not segregated according to their types of problems when receiving group therapy. Counseling of families and follow-up of patients after discharge are features of the program.

VOCATIONAL GUIDANCE

685. Arnholter, Wynne (6743 E. Michigan St., Indianapolis, Ind.)

Vocational rehabilitation. *Month. Bul.*, Ind. State Board of Health. July, 1960. 62:7:10-11, 16.

The psychological consultant to Indianapolis Goodwill Industries reports findings of a two-year study of a demonstration project supported by the U.S. Office of Vocational Rehabilitation. The program was designed to determine effectiveness of technics used in a 12-week period of prevocational testing and guidance of persons referred as unemployable because of physical and/or emotional problems. Data on 100 persons completing the program during the first two years of the study are presented. Dr. Arnholter presented this paper at the Annual Meeting of the World Federation of Mental Health in Edinburgh in August.

686. Kolstoe, Oliver P. (704 S. Forest St., Carbondale, Ill.)

The employment evaluation and training program. *Am. J. Mental Deficiency.* July, 1960. 65:1:17-31.

This project, now in its third year, is being conducted under a demonstration grant from the U.S. Office of Vocational Rehabilitation at Southern Illinois University. The 18-week program is designed to investigate and increase the vocational potential of mentally handicapped males over 16 years of age. Vocational evaluation and testing during the first three weeks attempt to assess intellectual, personal, social, and vocational skills of

trainees. The final 15 weeks are used to evaluate use of these skills in five different work situations for three weeks each. Work placement and follow-up are provided when the trainee leaves the project.

See also 627.

VOCATIONAL GUIDANCE— STUDY UNITS AND COURSES

687. San Francisco State College (Dr. William M. Usdane, 1600 Holloway St., San Francisco 27, Calif.)

Preliminary seminars on curriculum development for rehabilitation counselor training programs . . . December 7, 8, and 9, 1959, March 28, 29, and 30, 1960. San Francisco, The College (1960). 48 p.

This report, representing tentative findings of a seminar held at San Francisco College, contains addresses and discussion group reports on general graduate curriculum content for rehabilitation counselor trainees. The seminar did not attempt to deal specifically with procedures or methodology for implementing training programs but was concerned with such curriculum aspects as the professional and interprofessional role of the counselor, counseling theory and technic, psychological and social aspects of disability, psychological testing and assessment methods, occupational information and employment, and medical information. Includes brief summaries of addresses presented: "Communication in curriculum building," by S. I. Hayakawa, and "The rehabilitation counselor and other professions in the therapeutic community," by Dr. Maxwell Jones. The British approach to rehabilitation for the severely handicapped was discussed by Dr. Jones.

WALKING

688. Wareham, G. N. (*St. Bartholomew's Hosp., London, E.C. 1, England*)

Early re-education of the hemiplegic patient. *Physiotherapy.* July, 1960. 46:7:198-201.

Describes a simple method of re-education of walking and balance for the hemiplegic patient that is used at St. Bartholomew's Hospital. The two basic essentials are immediate activity (treatment should be started within 24 hours of full return to consciousness) and early ambulation. Regardless of the severity of paralysis, all such patients can learn to walk early by this method that helps to prevent drop foot. In this article treatment of a right hemiplegic is explained. The paper is based on a lecture given at the 1959 World Congress for Physical Therapy.

Events and Comments

Booklet Published on *How To Deal with Mental Problems*

THE BOOKLET *How To Deal with Mental Problems*, written by psychologist Harry Milt, information director of the National Association for Mental Health, and sponsored by the Association and The Advertising Council, replaces the popular brochure *How To Deal with Your Tensions*. More than 1,500,000 free copies of the "Tensions" booklet have been distributed since it was first introduced by The Advertising Council in June, 1957. Single free copies of the new 13-page booklet may be obtained by writing Better Mental Health, Box 2500, New York, N.Y.

Milwaukee Study To Investigate Rearing of Handicapped Children

FINANCED by a \$150,000 grant from the National Institutes of Health, a three-year study of how parents rear handicapped children will be conducted in Milwaukee by the Handicapped Child Development Center in co-operation with the Jewish Vocational Services of Milwaukee. About 1,000 parents will be asked about their children's feeding, toilet training, recreation, discipline, and safety education. A representative group of normal children will be controls. Taking part in this study, the first of its kind, will be Daniel Miller, Ph.D., and Robert Sears, Ph.D., professors of psychology at the University of Michigan, William Sewell, Ph.D., professor of psychology at the University of Wisconsin, and Seymour Sarason, Ph.D., professor of psychology at Yale University.

Dr. William G. Lennox Dies

ON JULY 21, Dr. William G. Lennox, world famed neurologist, died at the age of 75. Founder of the American Epilepsy League, he was president also of the International League Against Epilepsy from 1935 to 1949.

More than 250 of Dr. Lennox's colleagues, patients, and friends had gathered in Boston on June 12, under the auspices of the American Epilepsy Federation, to honor him with "An Evening with Dr. Lennox" and to celebrate publication of his two-volume book *Epilepsy and Related Disorders* (Little, Brown and Co.). Shortly thereafter, his failing health resulted once more in a stroke and he was hospitalized.

A Comment on

State Legislation for 1959 Relating Workmen's Compensation To Rehabilitation

"FIVE STATES [in 1959] enacted legislation relating to the rehabilitation of injured workers.

"Connecticut authorized rehabilitation payments for the first time. Weekly payments of up to \$15, in addition to compensation for temporary disability, were provided for employees undergoing rehabilitation.

"Utah raised the maximum amount payable for rehabilitation of an injured worker from \$700 to \$735, and Ohio increased the maximum maintenance payment during rehabilitation from \$20 to \$40.25. Florida authorized the Industrial Commission to assist an injured worker to obtain rehabilitation services if it appears that the disability probably will be permanent (formerly, if it was adjudged to be permanent), or if there is a reasonable probability that with rehabilitation the worker will require less care and attention, as well as if there is a reasonable probability that he can become employed or can increase his earnings.

"In California, the Department of Education was directed to continue a study of the problems of rehabilitation of industrially disabled workers."—From *Major Workmen's Compensation Legislation Enacted in 1959*, p. 32-33, in *Workmen's Compensation Problems; proceedings of the 45th annual convention of the International Association of Industrial Accident Boards and Commissions, Boston, Mass., Sept. 27-Oct. 1, 1959. (Bul. 213, U.S. Dept. of Labor, Bur. of Labor Standards) 1960. 234 p. U.S. Superintendent of Documents, Washington 25, D.C. 65¢.*

ICD To Expand Physical Plant

THE INSTITUTE for the Crippled and Disabled, New York, will erect a \$3 million building on the south side of East 24th Street between First and Second Avenues. The six-story structure will be ready for occupancy in 1962. It will be located about 200 feet from the Institute's present 11-story rehabilitation center. The new building is made possible through the generosity of Jeremiah Milbank and his brother, the late Dunlevy Milbank, as a memorial to their parents, Joseph and Ella Dunlevy Milbank. The rehabilitation research and professional teaching programs of the Institute will be greatly expanded when the new building is completed.

University of Kansas Receives Two Easter Seal Foundation Grants

A RESEARCH specialist will be chosen at the University of Kansas by Jan. 1, 1961, to receive a \$10,000 grant from the Easter Seal Foundation as a career research investigator. He will conduct a study of the relationship between body structure and behavioral functioning as a possible source of psychological understanding about man and his relationships to his environment. The investigator will be selected by Dr. M. Erik Wright, professor of the University's departments of psychology and psychiatry, and Dr. Franklin C. Shontz of the department of psychology.

The Foundation is also granting \$10,983 to the University for research to help correct speech problems of children with cleft palate. Ralph Shelton, Jr., Ph.D., assistant professor of speech pathology at the hearing and speech department of the Medical Center, will conduct the project with children aged 8 to 12 years. Radiologic and speech rating procedures will be used and speech samples will be obtained in filming and recording sessions.

World's First Nursing Home Research Center Planned

THE JULY issue of *Nursing Homes* (American Nursing Home Association, 1346 Connecticut Ave., N.W., Washington 6, D.C.) reports and describes plans for the construction in the District of Columbia of the world's first nursing home research center. Privately financed, the International Nursing Home Education, Research, and Service Center will have a school to train nursing home administrators and personnel, the world's most extensive library on care of the aged, a model nursing home, a permanent display of nursing home equipment, and research facilities.

Frank C. Bateman, executive director of the American Nursing Home Association, conceived and organized the Center. National leaders in government, civil affairs, and medicine are serving the nonprofit organization without pay. Senator John J. Sparkman is chairman of the board of advisors.

The site has not yet been definitely selected. Estimated costs, including the first year's operation, exceed \$500,000. An initial \$80,000 grant from Mutual of Omaha has made possible the planning stage.

Dr. Fraenkel Comments on Work Programs for The Mentally Retarded

"CURRENT INFORMATION indicates that there are at this time more than 100 training facilities offering vocational rehabilitation services to the mentally retarded. A large percent of these programs provide the six services outlined below:

1. Screening-Admissions
2. Evaluation
3. Personal adjustment training
4. Vocational training
5. Selective placement
6. Follow up

"A number of workshops serving the mentally retarded accept other disabled. Some of these facilities serve mentally retarded with secondary disabilities. A few serve mentally retarded of all groups fixing no upper or lower limit on intellectual functioning. Programs provide services from eight weeks to a year. In addition, a considerable number of the 127 current Goodwill Industry programs serve the mentally retarded. The majority of the 22 Jewish Vocational Service agencies which operate sheltered workshops offer evaluation and training to the mentally retarded.

"Through the U.S. Office of Vocational Rehabilitation Research and Demonstration Program, there are currently 13 projects investigating a wide range of services and needs germane to the vocational rehabilitation of the mentally retarded. There are in addition some 21 special OVR projects called 'Selected Demonstration in Vocational Rehabilitation' which are assessing vocational potentials of mentally retarded young adults.

"The Office of Vocational Rehabilitation rehabilitated 1,094 mentally retarded persons under the state-federal vocational rehabilitation program in fiscal 1957. . . ."—From *"Work Programs for the Mentally Retarded,"* by William A. Fraenkel, Ph.D., consultant, vocational rehabilitation and sheltered workshops, National Association for Retarded Children, and presented at the National Conference on Social Welfare, Atlantic City, N.J., June 9, 1960.

Conference To Be Held On Rehabilitation Psychology

AN INVITATIONAL Conference on Research in Psychological Aspects of Rehabilitation is being held in mid-November, 1960, by the American Psychological Association. The conference, supported by a grant from the U.S. Office of Vocational Rehabilitation, is a follow-up of the Princeton Institute (see *Rehab. Lit.*, Dec., 1959, #887) and a report by Lee Meyerson, current president of the National Council on Psychological Aspects of Disability, analyzing research needs in rehabilitation psychology. Chairman of the planning committee for the conference is Lloyd Lofquist of the University of Minnesota.

Lasker Award Winners For 1960 Announced

PAUL W. BRAND, F.R.C.S., Mary E. Switzer, and Gudmund Harlem, M.D., received the 1960 Albert Lasker awards in international rehabilitation. The awards were presented at the banquet of the Eighth World Congress of the International Society for the Welfare of Cripples, September 1, in New York City. Dr. Brand is the author of the article "Life After Leprosy Through Rehabilitation," which was published in the August issue of *Rehabilitation Literature*. He is the director of orthopedic surgery at the Christian Medical College, Vellore, India, and is a medical pioneer in reconstructive hand surgery for leprosy patients. Miss Switzer has been director of the U.S. Office of Vocational Rehabilitation since 1950. Dr. Harlem, Minister of the Royal Norwegian Ministry of Health and Social Affairs, was physician-in-charge of the State Rehabilitation Centre, Oslo, from its inception in 1946 to 1955, when he assumed his present office.

Pallidectomy To Be Evaluated by V.A.

SEVEN V.A. hospitals have undertaken a program of evaluating the surgical relief of Parkinson's disease by pallidectomy. Since the method is not applicable in all cases, only a small number of the 2,000 veterans treated for Parkinson's disease each year will receive this treatment. Dr. Lyndon E. Lee, Jr., of the V.A. office in Washington will serve as co-ordinator of the project.

New York State Names Health Department Assistant Commissioners

RECENTLY ANNOUNCED by Dr. Herman E. Hilleboe, State Health Commissioner of New York, are the appointments of Dr. I. Jay Brightman of Albany as Assistant Commissioner for Chronic Disease Services and Dr. Edward R. Schlesinger, also of Albany, as Assistant Commissioner for Special Health Services. Dr. Schlesinger's appointment was effective June 30.

The two divisions were established under a reorganization of the Department. The Special Health Services division includes the Bureaus of Medical Defense, Dental Health, Maternal and Child Health, Medical Rehabilitation, Nutrition, Narcotics Control, Funeral Directing, and the New York State Rehabilitation Hospital, West Haverstraw.

Units in the new division, Chronic Disease Services, include the Bureaus of Cancer Control, Chronic Disease and Geriatrics, Tuberculosis Case Finding, Tuberculosis Hospitals, Tuberculosis Control in State Institutions, and Roswell Park Memorial Institute, Buffalo.

Humor in the Physical Therapy Department

PHYSICAL THERAPISTS may take their work seriously, but they can also show their sense of humor with patients. You too will be amused by the booklet of cartoons *Physical Therapy Laughter* drawn by M. P. Gutierrez. The cartoons, first displayed in the physical therapy department of the University of Texas Medical Branch at Galveston, are based on Mr. Gutierrez's observations and experience while a patient there for two years. He dedicates his booklet to Ruby Decker, director of the School of Physical Therapy, and to Dr. E. Burke Evans, director of orthopaedic research. The booklet can be obtained from Mr. Gutierrez, 106 Marlin St., Galveston, Tex., at \$1.00 a copy.

Dr. Kandle Comments on

Administrative Problems In Long-Term Care

"LONG-TERM care does not necessarily imply care in a supine position on a bed. Rather it means medically prescribed rehabilitative procedures, instituted early and intensively and carried out for a sufficient period of time to secure a realistic goal with a minimum of handicap. The continuity of the service—whether as a bed patient, varying degrees of ambulation, care at home or in a nursing home—is a major ingredient. . . .

"Long-term care does not necessarily imply only care in a single institution, or bed care only, or 'purely custodial.' The necessity for the package of services, that are now the essence of long-term care, gets us into difficulty from the point of view of administration. The missing links are administrative machinery and acceptable methods of getting all the parts to work smoothly together. In New Jersey, we have many of the facilities in reasonable quantity and often of high quality. While the job is far from done, our problems are not those of gross inadequacies. We do have administrative problems. Some of these are financial, some are ideological, and some are developmental and are the product of our parochial, municipal, and other small service area concepts. The relatively simple issues of discharge, readmission, referral, transfer, or trying to put together services from multiple sources linked to who pays for what, are often the core of everyday problems of long-term care."—From *"The Hospitals Look at Long-Term Care,"* by Roscoe P. Kandle, M.D., State Commissioner of Health, and presented at a meeting of the New Jersey Hospital Association, Princeton, N.J., March 1, 1960; in *Public Health News, New Jersey State Department of Health*, June, 1960, p. 190.

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